EXAMINING H.R. ————, THE TRAFFICKING AWARENESS TRAINING FOR HEALTH CARE ACT OF 2014

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

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C O N T E N T S

[1] The President's Advisory Council on Faith-based and Neighborhood Partnerships report "Building Partnerships to Eradicate Modern-Day Slavery" is available at http://docs.house.gov/meetings/IF/IF14/20140911/102647/HHRG-113-IF14-Wstate-ChonK-20140911-SD005.pdf.

EXAMINING H.R. ————, THE TRAFFICKING AWARENESS TRAINING FOR HEALTH CARE ACT OF 2014

THURSDAY, SEPTEMBER 11, 2014

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:00 a.m., in room 2123, Rayburn House Office Building, Hon. Joseph R. Pitts (chairman of the subcommittee) presiding.

Members present: Representatives Pitts, Burgess, Ellmers, Pallone, Green, and Barrow.

Staff present: Leighton Brown, Press Assistant; Brenda Destro, Professional Staff Member, Health; Sydne Harwick, Legislative Clerk; Katie Novaria, Professional Staff Member, Health; Tim Pataki, Professional Staff Member; Heidi Stirrup, Policy Coordinator, Health; Ziky Ababiya, Democratic Staff Assistant; and Hannah Green, Democratic Policy Analyst.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. PITTS. The subcommittee will come to order.

The Chair will recognize himself for an opening statement.

Today's hearing focuses on H.R. 5411, The Trafficking Awareness Training for Health Care Act of 2014. The bill would support the development of evidence-based best practices for healthcare providers to identify and assist victims of human trafficking. Healthcare providers are among the few professionals who have the opportunity to interact with trafficked women and girls.

Because of unusual House scheduling conflicts today, we had to delay the start of today's hearing. And, therefore, we will dispense with members' oral opening statements. However, members' full written statements will be included in the record.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

The subcommittee will come to order.

The Chair will recognize himself for an opening statement.

Trafficking is an issue that many people believe only happens abroad, in a Third World country, not in America. But trafficking is happening in our own backyard and at an alarming rate.

The United States has become one of the largest markets for trafficking with profits in the billions of dollars. As a father and a grandparent, this is alarming to know that so many women and children are at risk. Although it is important for Americans to become more aware of this issue, awareness must be accompanied by action.

I would like to commend my colleague from North Carolina, Renee Ellmers, for her concern for the women and children involved in this illegal and harmful industry and for proposing H.R. 5411, the Trafficking Awareness Training for Health Care Act of 2014.

The bill would support the development of evidence-based best practices for healthcare providers to identify and assist victims of human trafficking. Health care providers are among the few professionals who have the opportunity to interact with trafficked women and girls. Placed in this unique and critical position, health care workers require heightened skills to help these women and girls.

Health care providers can often interact with victims while they are still in captivity. One study found that 28 percent of trafficked women saw a health care professional while being held captive. Data shows that these victims use emergency room and health centers for their care. When providers are trained about human trafficking, they have the knowledge and skills to provide assistance that can lead to improved care and even rescue.

I would like to welcome all of our witnesses here today. We look forward to learning from your expertise and experience.

[H.R. 5411 follows:]

.....

(Original Signature of Member)

113TH CONGRESS
2D SESSION

H. R. 5411

To provide for the development and dissemination of evidence-based best practices for health care professionals to recognize victims of a severe form of trafficking and respond to such individuals appropriately, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

Mrs. ELLMERS introduced the following bill; which was referred to the Committee on _____

A BILL

To provide for the development and dissemination of evidence-based best practices for health care professionals to recognize victims of a severe form of trafficking and respond to such individuals appropriately, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Trafficking Awareness Training for Health Care Act of 2014".

SEC. 2. DEVELOPMENT OF BEST PRACTICES.

(a) GRANT FOR DEVELOPMENT OF BEST PRACTICES.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services, acting through the Administrator of the Agency for Healthcare Research and Quality, shall award, on a competitive basis, a grant to an eligible school under which such school will—

(1) not later than 6 months after receipt of the award, develop best practices for health care professionals—

(A) to recognize victims of a severe form of trafficking; and

(B) to respond appropriately to such individuals; and

(2) in developing best practices under paragraph (1), survey, analyze, and evaluate existing best practices that foster the practice of interprofessional collaboration, including those used by industries other than the health care industry, to determine the extent to which such existing best practices may be adapted for use as part of the best practices under paragraph (1).

(3) develop curricula, training modules, or materials to train health care professionals on the best practices developed under paragraph (1);

(4) not later than 12 months after the receipt of the award, make a subgrant to one entity in each of the 10 administrative regions of the Department of Health and Human Services—

(A) to design, implement, and evaluate a pilot program using the best practices developed under paragraph (1) and the curricula, training modules, or materials developed under paragraph (3);

(B) to conduct the pilot program at one or more eligible sites within the respective region, which may include an eligible site that is a school-based health center; and

(C) to complete the implementation and evaluation of such pilot program with a period of 6 months;

(5) not later than 24 months after the receipt of the award, analyze the results of the pilot programs conducted through subgrants under paragraph (4), including analyzing—

(A) changes in the acquired skills, knowledge, and attitude of health care professionals resulting from the implementation of the programs;

(B) the number of victims of a severe form of trafficking who are recognized under the programs;

(C) of those recognized, the number who received information or referrals for services offered through the programs; and

(D) of those who received such information or referrals—

(i) the number who participated in followup services; and

(ii) the type of followup services received;

(6) determine, using the results of the analysis under paragraph (5), the extent to which the best practices developed under paragraph (1) are evidence-based; and

(7) submit a comprehensive assessment of the pilot programs conducted through subgrants under paragraph (4) to the Secretary of Health and Human Services, including an identification of—

(A) the best practices that are determined pursuant to paragraph (6) to be evidence-based; and

(B) the best practices that are determined pursuant to such paragraph to require further

review in order to determine whether they are evidence-based.

(b) CONTENTS.—The best practices developed through the grant awarded under subsection (a)—

(1) shall address—

(A) indicators to recognize victims of a severe form of trafficking;

(B) application of Federal and State law with respect to victims of a severe form of trafficking;

(C) patient safety and security, including the requirements of HIPAA privacy and security law as applied to victims of a severe form of trafficking;

(D) the management of medical records of patients who are victims of a severe form of trafficking;

(E) public and private social services available for rescue, food, clothing, and shelter referrals;

(F) the hotlines for reporting human trafficking maintained by the National Human Trafficking Resource Center and the Department of Homeland Security; and

(G) assessment tools for the identification of victims of a severe form of trafficking; and

(2) shall not address patient medical treatment.

(c) DISSEMINATION.—Not later than 24 months after the award of a grant to a school under subsection (a), the Secretary of Health and Human Services, acting through the Administrator of the Agency for Healthcare Research and Quality, shall—

(1) post on the public website of the Department of Health and Human Services the best practices that are identified by the school under subparagraphs (A) and (B) of subsection (a)(7); and

(2) disseminate to health care profession schools the best practices identified by the school under subsection (a)(7)(A) and evaluation results.

SEC. 3. DEFINITIONS.

In this Act:

(1) The term "health care professional" means a person employed by a health care provider who provides to patients information (including information not related to medical treatment), scheduling, services, or referrals.

(2) The term "HIPAA privacy and security law" has the meaning given to such term in section

3009 of the Public Health Service Act (42 U.S.C. 300jj–19).

(3) The term "victim of a severe form of trafficking" has the meaning given to such term in section 103 of the Trafficking Victims Protection Act of 2000 (22 U.S.C. 7102).

(4) The term "eligible school" means an accredited school of medicine or nursing with experience in the study or treatment of victims of a severe form of trafficking.

(5) The term "eligible site" means a health center that is receiving assistance under section 330, 399Z–1, or 1001 of the Public Health Service Act (42 U.S.C. 254b, 300).

SEC. 4. NO ADDITIONAL AUTHORIZATION OF APPROPRIATIONS.

No additional funds are authorized to be appropriated to carry out this Act and the amendments made by this Act, and this Act and such amendments shall be carried out using amounts otherwise available for such purpose.

Mr. PITTS. On our first panel today, we have Ms. Katherine Chon, a senior policy advisor at the Administration for Children and Families at the Department of Health and Human Services.

And I understand that Ms. Chon must leave by 10:30 today for the airport. So to maximize members' opportunities for questions of Ms. Chon, I will ask her to please summarize her statement in a few minutes.

And, with that, Ms. Chon, you are recognized. You may begin.

STATEMENT OF KATHERINE CHON, SENIOR ADVISOR ON TRAFFICKING IN PERSONS, ADMINISTRATION FOR CHILDREN AND FAMILIES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. CHON. Chairman Pitts, Ranking Member Pallone, and members of the subcommittee, thank you for inviting me to share with you the Department of Health and Human Services' work to prevent and end human trafficking in all of its forms.

HHS recognizes that human trafficking is not only a violent crime, but it is also a global health problem. The goals of The Trafficking Awareness Training for Health Care Act of 2014 would complement HHS's anti-trafficking efforts to build a capacity of first responders to identify and serve victims of human trafficking.

In our ongoing engagement with healthcare providers, this week HHS started a series of our pilot SOAR to Health and Wellness Training for Health Care Professionals, in which SOAR stands for Stop, Observe, Ask, and Respond to human trafficking.

This training seeks to increase knowledge on the diversity of human trafficking, identify indicators, utilize trauma-informed care, and connect with local and national service referral resources for trafficking victims.

We are partnering with local hospitals and community clinics in Atlanta, Boston, Houston, Oakland, and Williston and New Town, North Dakota, for the trainings, which will be evaluated later this fall.

While the SOAR trainings currently target healthcare providers through hospitals and community clinics, the bill broadens the reach of training efforts to health professions schools.

In addition to accredited schools of medicine and nursing, we recommend dental and social work schools as important target audiences because research has shown that victims of trafficking have encountered dentists and hospital- and clinic-based social workers are often responsible for managing the follow-up services once a victim has been identified.

The bill also references evidence-based practices. Since there is little evidence-based research specifically on the intersection of the healthcare system and human trafficking, the anti-trafficking fields may be able to adapt lessons learned from efforts in related issue areas, including the treatment of domestic violence and sexual assault victims in healthcare settings.

Additional opportunities for healthcare engagement include building the capacity of public health professionals to help prevent human trafficking, including interventions like the John schools, which provide information to purchasers of commercial sex who

have been arrested and then participate in educational programs on the health and behavioral health consequences of their actions.

The Administration looks forward to working with each of you to build the capacity of healthcare professionals to address the needs of victims of human trafficking.

Again, thank you for the opportunity to testify today. And I would be happy to answer any questions.

[The prepared statement of Ms. Chon follows:]

Statement by

Katherine Chon
Senior Advisor on Trafficking in Persons
Administration for Children and Families
U.S. Department of Health and Human Services

Before the

Subcommittee on Health
Committee on Energy and Commerce
United States House of Representatives

On

September 11, 2014

Chairman Pitts, Ranking Member Pallone, and members of the Subcommittee, thank you for inviting me to testify. I am pleased to have the opportunity to share with you the Department of Health and Human Services' (HHS) work to prevent and end human trafficking in all of its forms and the Administration's views on the proposed "Trafficking Awareness Training for Health Care Act of 2014."

I am Katherine Chon, Senior Advisor on Trafficking in Persons at the Administration for Children and Families (ACF), which is responsible for implementing the Department's anti-trafficking authorities under the Trafficking Victims Protection Act, in coordination with other HHS divisions and federal partners. Prior to my federal service, I co-founded an international nonprofit organization focused on combating human trafficking and spent a decade in the field working directly with survivors of trafficking, establishing effective victim service programs, and analyzing data and trends to inform public policy.

HHS seeks to prevent human trafficking, protect victims of its diverse forms of exploitation, and support survivors. As a member of the President's Interagency Task Force to Monitor and Combat Trafficking in Persons, HHS recognizes that human trafficking is not only a violent crime and grave human rights abuse, but it is also a global health problem. Through ACF, HHS addresses the social determinants of health and responds to human trafficking by integrating anti-trafficking responses across multiple human service systems – including child welfare, runaway and homeless youth, domestic violence, refugee resettlement, and Native American community services – working with populations at high risk to human trafficking.

Research has shown that victims of human trafficking often come into contact with the health care and behavioral health systems. Along with law enforcement personnel, health care providers are among the most likely frontline provider who may interact with victims of human trafficking while they are still under conditions of exploitation. In a 2011 study[1], 50 percent of foreign national survivors of sex and labor trafficking interviewed gave a history of encountering a health care professional while they were in a situation of human trafficking, yet none of them were identified as a victim during these encounters. In a 2014 study[2], almost 88 percent of interviewed survivors of domestic sex trafficking had encountered one or more health care professionals sometime during the period in which they were being trafficked, yet none were identified as a victim during these encounters. As concerning as these statistics are, the lack of research in the area of human trafficking limits our understanding of the health service needs facing this population, and how those needs would best be met.

Victims of human trafficking encounter a variety of health care professionals while still trafficked – this is an often missed opportunity to intercede. In a separate 2014 briefing[3] based on an anonymous nation-wide health care survey of sex and labor trafficking victims, 39 percent

[1] Baldwin SB, Eisenman DP, Sayles JN, Ryan G, Chuang KS. Identification of human trafficking victims in settings. *Health Hum Rights*. 2011; 13(1):1-14

[2] Lederer L, Wetzel CA. The health consequences of sex trafficking and their implications for identifying victims in facilities. *The Annals of Health Law*. 2014; 23(1):61-91.

[3] Chisolm-Straker M, Richardson L, Baldwin S, Gaïgbé-Togbé B, Ndukwe N, Johnson P. Trafficking Victims & Health Care: A Survey of Survivors. Power Point. 2014.

of respondents had contact with emergency departments, 29 percent with primary care providers, 17 percent with obstetrician and gynecologists, 17 percent with dentists, and three percent with pediatricians.

SOAR to Health and Wellness Training for Health Care Professionals

HHS has worked to engage health care providers during its history of implementing anti-trafficking programming. In 2008, the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) sponsored a National Symposium on the Health Needs of Human Trafficking Victims, bringing more than 150 health care professionals, anti-trafficking experts, and federal partners together to discuss victim identification and services in health care settings.

Major discussion points of the symposium, which are available on the HHS website, included:

- The important role of health care providers in screening for human trafficking in high risk populations,
- The need for addressing mental health concerns among survivors of trafficking as well as the vicarious trauma that often occurs among service providers, and
- The recognition that human trafficking is an issue with public health consequences impacting prevalence of tuberculosis, HIV/AIDS, and Hepatitis B.

One of the major outcomes of the symposium was the call for increased training for health care professionals in diverse disciplines, including physicians, nurses, dentists, counselors, hospital-based mental health care providers, school-based health care providers, and first responders.

This week, HHS is beginning a series of our pilot SOAR to Health and Wellness trainings for health care professionals, in which SOAR stands for "Stop, Observe, Ask, and Respond to Human Trafficking." We are partnering with local hospitals and community clinics in Atlanta, Boston, Houston, Oakland, and Williston and New Town, North Dakota for the trainings, which will be evaluated later this fall. The training will equip health care professionals to:

- Describe the scope, diversity, and types of human trafficking in the United States,
- Recognize the common indicators and high-risk factors for human trafficking,
- State how using trauma-informed techniques will enhance interaction with a potential victim of human trafficking, and
- Identify local, state, and national service referral resources for trafficking victims.

The training seeks to decrease known provider-related barriers to identifying victims of human trafficking, which include lack of knowledge, misclassification, non-trauma informed care, judgment, and cultural assumptions.

Trafficking Awareness Training for Health Care Act of 2014

The "Trafficking Awareness Training for Health Care Act of 2014" would complement HHS' anti-trafficking efforts to engage the health care community by increasing information,

awareness, and training for health care providers. While the pilot HHS SOAR to Health and Wellness training currently targets health care providers through hospitals and community clinics, HHS recognizes the importance of integrating awareness of and skills to combat human trafficking into health professions schools. In addition to accredited schools of medicine and nursing, we recommend dental and social work schools as important target audiences because research has shown that victims of trafficking have encountered dentists and hospital and clinic-based social workers who are often responsible for managing the follow-up social and behavioral health services referral process once a victim has been identified.

Unfortunately, there is little evidence-based research on the intersection of the healthcare system and human trafficking, especially when it comes to the impact of training efforts. Therefore, it may be difficult to develop best practices according to the timeline noted in the bill. An alternate option is to identify and develop "promising practices." The anti-trafficking field may be able to adapt lessons learned from efforts in related issue areas, including treatment of domestic violence and sexual assault victims in health care settings. HHS is concerned that the bill requires, rather than allows the Secretary to make best practices grants and specifies that these grants be made within existing resources. Further, in order to ensure that the program is placed in the HHS agency with the available expertise to carry it out, HHS prefers that the Secretary have the authority to delegate the grant program to the appropriate HHS component.

In 2010, ASPE released an issue brief, "Medical Treatment of Victims of Sexual Assault and Domestic Violence and Its Applicability to Victims of Human Trafficking," that outlined a number of recommendations including:

- The need for comprehensive screening practices: Although there are no universal screening practices on domestic violence in healthcare settings, lessons learned include the effectiveness of posting signs and literature to supplement routine screening and to reinforce the health care setting as a safe place to seek assistance; and to conduct screenings in a private setting away from perpetrators who may accompany potential victims.
- The importance of examination protocols: There is a limited number of evidence-based clinical practices for examination and treatment of victims of sexual assault, but there are lessons that can be applied in anti-trafficking responses including the importance of having an advocate trained in crisis intervention present with the potential victim and integrating information on human trafficking into Sexual Assault Nurse Examiner (SANE) trainings.
- The content of effective training: Training on domestic violence and sexual assault is most effective when it provides information on the internal and external resources available to support comprehensive service delivery, teaches practical skills (e.g. interview techniques, safety assessment, documentation), and informs health care practices to detect and reduce barriers to identification.

The ASPE issue brief also describes how the Joint Commission on Accreditation of Healthcare Organizations, a nonprofit organization that evaluates and accredits more than 17,000 hospitals, healthcare networks, and other healthcare organizations in the United States, has adopted guidelines requiring that member hospitals and organizations have objective criteria for

identifying victims of physical assault, sexual assault, domestic violence, and abuse of elders and children. Members must train staff on identification and maintain a list of referral organizations that provide assessments and care for victims. Human trafficking responses could also be integrated into such approaches.

Additional Opportunities for Healthcare Engagement

The public health community has been engaged in anti-trafficking efforts, mostly focused on the prevention of HIV/AIDS and other communicable diseases. Public health professionals have also been engaged in "john schools" in some parts of the country, providing information to purchasers of commercial sex who are arrested and participate in educational programs that may be diversions programs, sentencing options, or combined with other penalties for criminal activity. Topics in these educational programs may include information on health and behavioral health consequences; impact of trauma on health and behavioral health, on communities, families, and survivors; male development, decision making, and health relationships; sex addiction; and anger management. John schools are currently located in more than 55 cities in the United States and serve 100 cities and counties.

Additionally, while many victims of human trafficking may come into contact with health care providers, health disparities may prevent others from accessing health care. According to the Department of Justice-funded study[4] of confirmed sex trafficking victims whose race was known, 26 percent were white, 40 percent were black, and 24 percent were Hispanic. Of confirmed labor trafficking victims, 56 percent were Hispanic and 15 percent were Asian. Future studies on the intersection of the healthcare system and human trafficking may want to consider further researching how to meet the health needs of trafficked persons representing populations that may not routinely reach out to the health care community.

Finally, the HHS SOAR to Health and Wellness training is one of many health and public health-related items that HHS has committed to in the *Federal Strategic Action Plan on Services for Victims of Human Trafficking in the United States*, which was released earlier this year and was developed collaboratively with the Department of Justice and the Department of Homeland Security. Members of the Subcommittee may be interested in other action items that HHS will be implementing through 2017 and beyond, which include:

- HHS's ACF and Substance Abuse and Mental Health Services Administration will provide a series of recommendations on meeting the mental health needs of victims. This follows up on ASPE's 2008 National Symposium on the Health Needs of Human Trafficking Victims.
- HHS will explore new data collection strategies, such as the rigor and feasibility of one-day census counts of persons receiving social services associated with their human trafficking experience and collecting data through public health methodologies, for compiling unduplicated estimates on the prevalence of human trafficking in the United States.

[4] Duren Banks and Tracey Kyckelhahn, Characteristics of Suspected Human Trafficking Incidents, 2008-2010, 1, (Washington, DC: Bureau of Justice Statistics, U.S. Department of Justice, 2011).

- HHS's Health Resources and Services Administration (HRSA) and intra-agency partners will consider adopting action from the HHS Action Plan to Reduce Racial and Ethnic Health Disparities to establish data standards for information collected related to victims of human trafficking.
- ACF will explore the development of standardized health care protocols for intake (including increased focus on medical history and past intimate partner violence), evaluation/examination, referrals, evidence collection, and long-term care (physical, oral, and mental) in human trafficking situations.
- HHS will collaborate through intra-agency efforts to develop and disseminate materials for public health organizations and associations.
- The Department of Homeland Security Office of Health Affairs will coordinate with HHS to support outreach and training efforts to engage medical first responder personnel and hospital staff in emergency rooms and clinic environments.
- ACF, in conjunction with other HHS components, will explore possibilities of partnering with social work schools, counseling schools, and related professional associations to increase training for social work and health professionals on meeting the needs of human trafficking victims.
- ACF and HRSA will consider strategies, in coordination with intra- and interagency partners, to raise awareness about human trafficking in community colleges.
- HHS will incorporate the topic of human trafficking in ongoing tribal consultations and identify information distribution channels to relevant programs through HHS's Indian Health Service.

The Administration looks forward to working with each of you to build the capacity of health care professionals to address the needs of victims and survivors of human trafficking.

Again, thank you for the opportunity to testify today. I would be happy to answer any questions.

[Additional information submitted by Ms. Chon is available at http://docs.house.gov/meetings/IF/IF14/20140911/102647/HHRG-113-IF14-Wstate-ChonK-20140911-SD005.pdf.]

Mr. PITTS. Thank you.

We will begin the questioning. I will recognize myself 5 minutes for that purpose.

Ms. Chon, according to the Compendium of State Statutes and Policies on Domestic Violence and Health Care, which was funded by HHS, it states that, "The goals potentially served by mandatory reporting include enhancing patient safety, improving healthcare providers' response to domestic violence, holding batterers accountable, and improving domestic violence data collection and documentation. However, upon closer examination, it becomes apparent that mandatory reporting does not necessarily accomplish these goals."

This statement seems to discourage mandatory reporting by healthcare workers. Is that the position of HHS? Is there research to support this position?

Ms. CHON. So I am less familiar with the mandatory reporting guidelines around domestic violence. But one thing that we have heard from healthcare providers specific to human trafficking is that there have been concerns—or questions from healthcare providers on reporting requirements balanced with HIPAA regulations when it comes to identifying victims of human trafficking.

And so what we are encouraging in our SOAR to Health and Wellness training is being familiar with HIPAA requirements but also familiar with the local and State statutes around mandatory reporting and the healthcare institutions' protocols around reporting.

And, universally, though, we do encourage identifying referrals for follow-up social services within the context of institution and State and local guidelines as well as Federal.

Mr. PITTS. Well, that statement seems to discourage mandatory reporting by healthcare workers.

Does that or should that position apply to human trafficking?

Ms. CHON. Well, in terms of mandatory reporting for human trafficking, part of it depends on the type of human trafficking that a healthcare provider may come across.

So for victims of child sex trafficking, for example, in many States, they are also victims of child abuse, according to the State laws, and there are very strict mandatory reporting guidelines there.

In our SOAR to Health and Wellness training, we do go over the specific situations in which mandatory reporting would be required by law.

Mr. PITTS. Can you explain what the stop, observe, ask, respond to human trafficking in the SOAR training program entails, how the training was developed and how the cities participating in the pilot were chosen.

Ms. CHON. Sure. This training is part of one of our many commitments in the Federal Strategic Action Plan on services to victims of human trafficking. It is an interagency plan, which HHS co-chaired with the Departments of Justice and Homeland Security.

And during the public comment process, the anti-trafficking field called for increased training for healthcare providers. So we identified and formed a national technical working group of subject matter experts, including many healthcare professionals across a wide spectrum of specialties that have experience in training healthcare providers.

We also had service providers and survivors of human trafficking inform the training. It went through Federal interagency review and was based on a literature review as well.

Because this is a pilot, we selected five sites in areas where we could develop strong partnerships with local stakeholders and healthcare providers who were already experienced in responding to this issue. So Boston, Oakland, Atlanta, and Houston were chosen for those reasons.

And then New Town and Williston, North Dakota, were chosen because there were concerns around the increase in various forms of violent crimes, including human trafficking, and the need for the healthcare system to receive training to identify and respond to a relatively new issue that they felt they were seeing in that area.

Mr. PITTS. Can you explain how HHS was involved in the development of the Federal Strategic Action Plan on services for human trafficking in the United States? And what goals has HHS set in the Strategic Action Plan?

Ms. CHON. The Strategic Action Plan has four primary goals set not just by HHS, but through a collection of more than a dozen Federal agencies and partners. It is available online. We would be happy to also provide a copy of it as well.

And, as I mentioned, we co-chaired this process with the Departments of Justice and Homeland Security. The draft plan was based on a number of community listening sessions across the country, national calls as listening sessions, as well as literature review.

And the draft was released for public comment last spring. And then Federal agencies reviewed the public comments throughout the summer and fall, finalized it, and then the final version was released this January.

Mr. PITTS. The Chair thanks the gentlelady.

Now yields to the ranking member, Mr. Pallone, for 5 minutes of questions.

Mr. PALLONE. Thank you, Mr. Chairman.

Last week I had the opportunity to visit the U.S.-Mexican border, and the Administration for Children and Families plays an important role there, providing critical health and welfare services to the unaccompanied children who cross that border every day.

We all know that the unprecedented number of unaccompanied minors have arrived in the U.S. and needed ACF's services this year. And Congress clearly has the responsibility to ensure that this agency has the resources that it needs to do this work.

We don't want the Administration for Children and Families to be forced to reallocate funds from other important programs, such as the ones we have heard about this morning.

So can you just discuss the importance of providing adequate funding for the Administration for Children and Families programs to address the needs of both domestic and foreign victims of human trafficking?

And in its fiscal year 2015 budget, ACF proposed an increase of $8.2 million to specifically assist domestic victims of human trafficking. Can you comment on the type of work the ACF plans to do with that money?

Ms. CHON. Sure. Well, the good news is we have not had to reallocate any of our anti-trafficking funds to address some of the unaccompanied minor needs that have risen over the past year.

In terms of the budget requests, the increase in funding will allow HHS to serve victims of all forms of trafficking, so foreign nationals as well as U.S. citizens and lawful permanent residents.

Pretty much over the last decade or so, the budget on addressing human trafficking has been fixed around $10 million, primarily going to serve foreign national victims of trafficking.

In this current fiscal year, we received an increase in appropriations, which gave us enough to provide demonstration grants to start serving domestic victims of trafficking, so U.S. citizens and lawful permanent residents.

And so what we intend to do, if there is a further increase in the budget, is to bring parity at least in the budget that goes to serve domestic victims to match up the budget that has been going to serve foreign national victims.

Mr. PALLONE. Thanks.

I also wanted to hear more about the SOAR for Health and Wellness initiative and the pilot trainings that are beginning this week.

So let me ask what kind of interest you have seen from the communities that are conducting pilot training over the next few weeks.

And after participants complete the pilot trainings, what kind of evaluations do you have planned? And what do you plan to use these evaluations for to think about the future of the SOAR program?

Ms. CHON. Sure. So there has been significant interest in the specific pilot locations. Registrations, we have been meeting our goals for this pilot program. We were targeting about 45 participants per site. And in some sites, like in North Dakota and Houston, there are multiple trainings that are being held.

And it is not just the pilot sites, but we are hearing from other communities. Healthcare providers are asking for additional resources on training and technical assistance, which HHS partly provides through our National Human Trafficking Resource Center. Healthcare providers can access that at any point.

Then, in terms of the evaluation, there is a pre- and post-test for this training, a 3-month evaluation survey, and a subset of the participants will participate in qualitative surveys as well. We will release the findings of the evaluation next spring.

Mr. PALLONE. All right. Earlier this year the Departments of Justice, Homeland Security, Health and Human Services released a Federal Strategic Action Plan on Services to Victims of Human Trafficking in the U.S., and it outlines a number of specific actions that different Federal agencies are going to take.

I understand you were involved in the development of this plan. What types of comments did you receive from healthcare profes-

sionals during this process regarding the need to improve the healthcare system's response to victims of human trafficking?

Ms. CHON. The overwhelming response that we received in the public comment process from healthcare providers was a need for additional training and resources, especially if it could be in some standardized way and, also, tailored to the specific healthcare professions. We also heard comments on having screening tools, especially if they could be validated and be evidence-based.

And the type of training that we are providing is different from a longer-term curriculum that could be available through educational institutions, but we also heard the importance of developing skills through curriculum-based efforts in educational institutions.

Mr. PALLONE. All right. Thanks.

I just wanted to say, with regard to the SOAR training, I am glad that HHS has evaluation steps in place to assess the effectiveness of the pilot program, and I think this work would provide helpful feedback as we think about what role Congress and the Federal Government can play in assisting the healthcare community to respond to the needs of trafficking victims.

So thanks again.

And thank you, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman.

And I now recognize the gentlelady from North Carolina, Mrs. Ellmers, for 5 minutes for questions.

Mrs. ELLMERS. Thank you, Mr. Chairman.

And thank you, Ms. Chon, for being with us today. I know you have limited time, so I will try to get through my time so that we can allow anyone else for questions.

First of all, I want to say thank you for what you are doing, and the SOAR program sounds like we are moving forward on a really good HHS initiative.

We feel very strongly that we want to expand that, and we want to make sure that we are reaching out and including our education for medical students and nurses. And that really has to do with what we are trying to achieve here with the bill that we have.

And, of course, as you know, funding is an issue. We want to make sure that there is adequate funding for this project.

I was wondering if you could comment from that perspective on some funds that are available through HHS, the Prevention and Public Health Fund, or the PPHF, which basically helps to fund innovative projects and outreach.

I believe that this is one of those areas that—especially when we are moving forward with health care—could be a positive funding source through HHS that is already there and call on Congress to appropriate funds to it.

Would you like to comment on that?

Ms. CHON. Sure. In terms of my knowledge of those particular funds, I don't believe they have been used for anti-trafficking training purposes in the past. But I certainly will ask the appropriate divisions within HHS how those funds could be used for these purposes and then would be happy to get back to you on those possibilities.

Mrs. ELLMERS. Great. That would be great if you could get back to the committee on the response to that. Because I think, as we are moving forward, we would like for this to move as quickly as possible. And, you know, we, too, have suggested a pilot program with feedback so that we know what is working and what isn't.

I think the training and the education component of it for our medical students and our nurses so that they are being exposed to this information—one of the things that I found over time that is so vital is that many people do not realize this is happening here in the United States and that this is something that we have to make sure that our healthcare providers are understanding and aware of.

I will yield back.

I just, again, want to thank you for being here today and thank you for sharing your information, and I am looking forward to working together on this.

Ms. CHON. Thank you.

Mrs. ELLMERS. I yield back.

Mr. PITTS. The Chair thanks the gentlelady.

I now recognize the gentleman from Georgia, Mr. Barrow, 5 minutes of questions.

Mr. BARROW. No questions.

Mr. PITTS. The Chair recognizes the vice chairman of the subcommittee, Dr. Burgess, for 5 minutes of questions.

Mr. BURGESS. Thank you, Mr. Chairman. I apologize for being late. There is a lot going on this morning.

Ms. Chon, thank you for being here. Your agency is one that has perhaps come to the attention of this subcommittee a great deal more over the last 6 months for a variety of reasons.

But as we are here today to discuss the prevention of human trafficking, I seem to detect that there is a system of best practices with evidence-based research and a system of promising practices.

Could you help me understand a little bit the differences between the two and why you favor one over the other?

Ms. CHON. Well, in the scientific community, there is always a prioritization around evidence-based practices—so, for example, the reason why we put funding into evaluating our trainings was because we wanted to have the evidence that the training was impactful and met the goals that we set out for it, as opposed to best practices or promising or emerging practices are those practices that seem to have impact, but there have not yet been rigorous evaluation just because the research funding wasn't there.

Mr. BURGESS. Well, what population of providers—or professionals are you likely to train in the program?

Ms. CHON. So it is healthcare providers across the spectrum from doctors, nurses, dentists, mental health providers, clinical social workers, school-based nurses as well because they truly are at the frontlines of early identification and, also, prevention of human trafficking so that the problem doesn't happen in the first place.

Mr. BURGESS. Might I just gently suggest that perhaps you could talk to professionals who are in the Office of Refugee Relocation, who are also under the Administration of Children and Families?

Because it seems to be missing from some of the hearings and briefings we have had on the issue of the unaccompanied minors in the lower Rio Grande Valley in my State of Texas.

In fact, your physician—and, unfortunately, a physician was only hired by ORR in May of this year, even with the understanding that the problem was tumultuous and growing for several months before that. And your doctor reported to us that they only investigated cases of sexual assault if the victims so self-identified. Of course, these are children that we are talking about who are coming into these centers.

In the State of Texas, it is a reportable crime. I am a physician. I was required by law to report to State authorities if I thought a child had been abused, let alone was a victim of sexual assault. But I was required by law and, if I didn't report it, I was in trouble.

And, yet, you have these children streaming across the Rio Grande River as unaccompanied minors, giving themselves up when they get across into Texas, taken into centers, evaluated by sometimes DMAT teams. And although they do great work, the level of training you have got to wonder about. ORR had just hired a doctor right before the summer started and, yet, they were only investigating cases where a child said, "Yes. I was a victim."

And I was down in those intake centers. You would have groups of kids sitting on a cement bench, a group of little 5-year-old boys—I have got a 5-year-old grandson. I know how hard it is to get a 5-year-old to sit still—five 5-year-old boys just sitting on this bench stone-still, staring into space. That is not normal. That is not normal behavior for a 5-year-old.

The cell was holding what looked like a class of third-grade girls except, yes, you realized they were all brought there or had turned themselves in. And these people had gotten across the entire country of Mexico through the deserts and the jungles and the difficulties by coyotes, who are human traffickers.

Why aren't they further investigated? And when those cases are found, why are they not reported to State authorities so someone can go after the people who are the perpetrators and stop this problem at least—if not once and for all, a least have a better handle on starting it?

We are enablers right now, as far as I can see. We are co-dependents with the child traffickers. And it is not a pretty story and does not reflect well on your agency. It does not reflect well on the Office of Refugee Resettlement. And it needs to stop.

Thank you, Mr. Chairman. I will yield back my time.

You may respond if you wish.

Mr. PITTS. Yes, please.

Ms. CHON. I think we have the same goals in mind in terms of protection for these unaccompanied minors. And I thank you for your passion and your concern for this population.

The Office of Refugee Resettlement, they are a part of a departmental working group on human trafficking, and I will learn more about what their practices are on the health piece in their screening for trafficking.

Mr. BURGESS. Let me just provide you some information. Every young woman or child, girl, who's brought into the center over the age of 10 is given a pregnancy test. I presume there is a reason

for that, because they think something might have happened during this long journey up here. But then they are not further queried about the possibility of sexual assault.

It is sort of like we are indifferent to the fact that these children may have been assaulted on the way up here. We are never going to be able to stop the bad guys if we don't do the fundamental police work. And your agency is sort of the tip of the spear there. That is where it should be happening, and, unfortunately, it is not.

Again, thank you, Mr. Chairman, for the indulgence.

Mr. PITTS. The Chair thanks the gentleman and thanks the witness for answering all your questions.

We know that you have to leave to catch a plane. We will send follow-up questions. And I know other members will have questions in writing to you. We will ask that you please respond promptly.

Ms. CHON. Thank you very much.

Mr. PITTS. Thank you very much, Ms. Chon, for your time.

And so we will dismiss our first panel and introduce the second panel at this time.

On our second panel we have—and if the staff can set that up and I will introduce them in the order of their presentation—first, Ms. Vednita Carter, Founder and Executive Director of Breaking Free. Then we have Ms. Laura Lederer, Director of the Bastian Center for the Study of Human Trafficking, Indiana Wesleyan University. Then we have Dr. Hanni Stoklosa, emergency physician, Brigham and Women's Hospital, and, finally, Dr. Ken Miller, President, American Association of Nurse Practitioners.

So if you will take your seats. Thank you all for coming. Your written testimony will made a part of the record. You will each be given 5 minutes to summarize your testimony.

And, Ms. Carter, we will start with you. You are recognized for 5 minutes.

STATEMENTS OF VEDNITA CARTER, FOUNDER AND EXECUTIVE DIRECTOR, BREAKING FREE; LAURA J. LEDERER, DIRECTOR, BASTIAN CENTER FOR THE STUDY OF HUMAN TRAFFICKING, INDIANA WESLEYAN UNIVERSITY; HANNI STOKLOSA, EMERGENCY PHYSICIAN, BRIGHAM AND WOMEN'S HOSPITAL; KENNETH P. MILLER, PRESIDENT, AMERICAN ASSOCIATION OF NURSE PRACTITIONERS

STATEMENT OF VEDNITA CARTER

Ms. CARTER. Chairman Pitts, Representative Ellmers and distinguished members of the committee——

Mr. PITTS. If you can press that button. Pull it up close so the light is on. Thank you.

Ms. CARTER. Chairman Pitts, Representative Ellmers, and distinguished members of the committee, thank you for inviting me to testify today to support this groundbreaking bill for the training of healthcare professionals to better work with victims of human trafficking.

My name is Vednita Carter. I am a survivor of sexual exploitation. I am also the founder and executive director of Breaking Free, a nonprofit agency in St. Paul, Minnesota.

Breaking Free's mission is to educate and provide services to women and girls who have been victims of abuse and sexual exploitation and need assistance escaping violence in their lives.

Breaking Free is a survivor-led organization and provides services to more than 500 victims each year. In the case of virtually every sex-trafficking victim we have worked with, they were recruited, coerced, defrauded, or forced into prostitution.

Once girls and women are involved in the life of sex trafficking, it is extraordinarily difficult for them to escape. We can never forget that sex trafficking is modern-day slavery.

Sex trafficking causes tremendous trauma for victims from the physical abuse, emotional abuse, sexual abuse, kidnapping, and torture they have experienced. It is a terrifying and dangerous life.

83 percent of our clients at Breaking Free were assaulted with a deadly weapon. 57 percent were kidnapped before they escaped sex trafficking. 86 percent suffer from some type of emotional, physical, or mental disability. 71 percent of the victims we serve suffer from post-traumatic stress disorder.

One survivor's story illustrates some of the health issues victims of sex trafficking face. As she told me, "I was trafficked when I was 11 years old by my foster mother, who let her boyfriend sell us to other men. By the time I was 12, I had a pimp. During this time, I was beaten, burned, raped, and assaulted. Sometimes I went to a local neighborhood health clinic to be treated, but no one ever asked me what had happened to me. And, if they did, I lied because I was afraid of my pimp. I had severe depression, anxiety, paranoia, and mental health issues, even after I became free. I got pregnant six times and had six abortions during this time. I had severe scar tissue from these abortions because there was no follow-up care. In a couple of cases, I had bad infections, so bad that I eventually had to have a hysterectomy. To this day, I have physical, mental, and emotional issues as a result of that time on the street."

Another survivor told me, "I was beaten, strangled, kicked, punched, raped, and hit on the head by my pimp. I wasn't able to escape until I was diagnosed with cervical cancer and, since then, I have been battling serious physical and mental health problems, including headaches, shortness of breath, bronchitis, chest pain, chlamydia, vaginal infections, and urinary tract infections. I also suffer from depression, anxiety, and panic attacks. I attempted suicide several times."

All too often victims of sex trafficking slip through the cracks of our medical system. Without appropriate training, health professionals are not able to put the pieces of the puzzle together to see that the woman or girl in their examination room is a sex-trafficking victim, or if the professional is able to see the signs, she or he doesn't know how to talk to a victim without shaming or retraumatizing her, or the professional may be unaware of community resources to help the victim.

Healthcare professionals are in an excellent position to identify and help victims, but they need coordinated, evidence-based, and trauma-informed training to be able to do so.

The Trafficking Awareness Training for Health Care Act of 2014 offers the medical community the opportunity to develop best prac-

tices for identifying and caring for victims and the opportunity to help thousands of victims in our Nation break free.

Thank you.

[The prepared statement of Ms. Carter follows:]

Testimony Before the House of Representatives Committee on Energy and Commerce
Subcommittee on Health

Hearing

"Examining H.R. ___, the Trafficking Awareness Training for Health Care Act of 2014"

Testimony
Vednita Carter
Founder and Executive Director, Breaking Free
778 University Avenue West
St. Paul, MN 55104

September 11, 2014

Chairman Pitts, Representative Ellmers, and distinguished members of the Committee, thank you for inviting me to testify today to support this groundbreaking bill for the training of health care professionals to better work with victims of human trafficking.

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In the case of virtually every sex trafficking victim we have worked with, they were recruited, coerced, defrauded, or forced into prostitution. Once girls and women are involved in the life of sex trafficking, it is extraordinarily difficult for them to escape. We can never forget that sex trafficking is modern day slavery.

Sex trafficking causes tremendous trauma for victims from the physical abuse, emotional abuse, sexual assault, kidnapping, and torture they have experienced. It is a terrifying and dangerous life. 83% of our clients at Breaking Free were assaulted with a deadly weapon and 57% were kidnapped before they escaped sex trafficking. 86% suffer from some type of emotional, physical, or mental disability. 71% of the victims we serve suffer from post-traumatic stress disorder.

One survivor's story illustrates some of the health issues victims of sex trafficking face. As she told me:

"I was trafficked when I was 11 years old by my foster mother, who let her boyfriend sell us to other men. By the time I was 12, I had a pimp. During this time I was beaten, burned, raped, and assaulted. Sometimes I went to a local neighborhood health clinic to be treated, but no one ever asked me what had happened to me, and if they did, I lied because I was afraid of my pimp. I had severe depression, anxiety, paranoia, and mental health issues, even after I became free. I got pregnant six times and had six abortions during this time. I had severe scar tissue from these abortions, because there was no follow up care. In a couple of cases I had bad infections—so bad that I eventually had to have a hysterectomy. To this day I have physical, mental, and emotional issues as a result of that time on the street."

Another survivor said:

"I was beaten, strangled, kicked, punched, raped, and hit on the head by my pimp. I wasn't able to escape until I was diagnosed with cervical cancer, and since then have I been battling serious physical and mental health problems including headaches, shortness of breath, bronchitis, chest pain, chlamydia, vaginal infections, and urinary tract infections. I also suffered from depression, anxiety, and panic attacks. I attempted suicide several times."

All too often, victims of sex trafficking slip through the cracks of our medical system. Without appropriate training, health professionals are not able to put the pieces of the puzzle together to see that the woman or girl in their examination room is a sex trafficking victim. Or if the professional is able to see the signs, she or he doesn't know how to talk to a victim without shaming or re-traumatizing her. Or the professional may be unaware of community resources to help the victim.

Health care professionals are in an excellent position to identify and help victims—but they need coordinated, evidence-based, and trauma-informed training to be able to do so. The "Trafficking Awareness Training for Health Care Act of 2014" offers the medical community the opportunity to develop best practices for identifying and caring for victims and the opportunity to help thousands of victims in our nation break free.

Thank you for the opportunity to testify today.

Mr. PITTS. The Chair thanks the gentlelady.

Now recognizes Ms. Lederer, 5 minutes for opening statement.

STATEMENT OF LAURA J. LEDERER

Ms. LEDERER. Thank you, Mr. Chairman, and members of the committee. Thank you for the invitation today to testify and for calling this hearing to address the health effects of human trafficking and the need for training for the healthcare provider sector.

Over the last decade, we have looked at human trafficking as a human rights abuse and as a criminal justice problem, but in the past 5 years, it has become clear that human trafficking also has serious public and private health consequences and that we need public policy and programmatic responses to train healthcare providers to identify victims and to respond appropriately.

Today I want to share with you the preliminary findings from a series of focus groups we conducted with domestic survivors of sex trafficking around the country. These focus groups provide evidence that women and children who are trafficked into prostitution are physically, mentally, emotionally devastated by the crime and this devastation is lasting with illnesses, injuries, and impairments starting during trafficking, but lasting often years longer.

The full set of findings in charts and tables is available in my written testimony. I am only going to outline the basic findings in my testimony here today.

Survivors suffer tremendously, virtually without exception. In our study, 99.1 percent reported that they had at least one physical health problem during trafficking, and the majority reported dozens of health issues ranging from neurological, cardiovascular, respiratory, gastrointestinal, gynecological, dental, and dermatological problems.

Survivors were also overwhelmingly traumatized not only physically, but mentally. The brutal treatment they endured created ongoing psychological and mental conditions in many victims and also exploited existing mental instability in others.

98.1 percent reported at least one psychological issue during their captivity, with an average of more than a dozen psychological health problems indicated, including depression, flashbacks, panic attacks, helplessness, hyper-alertness, disassociation, depersonalization, suicidal ideation, attempted suicide, post-traumatic stress disorder.

Not surprisingly, survivors also reported significant numbers of reproductive health problems. More than two-thirds of the survivors we talked to contracted some form of sexually transmitted disease or infection, some STD or STI, including gonorrhea, syphilis, herpes, or chlamydia.

Survivors also reported many issues around pregnancy. 71.2 of the survivors we talked to reported at least one pregnancy while being trafficked. 21.2 percent reported five or more pregnancies. 57.7 percent said they had at least one miscarriage. 29 percent said they had more than one miscarriage while being trafficked. 55.2 percent reported at least one abortion, with 30 percent reporting multiple abortions during the time that they were trafficked.

The prevalence of forced abortion is an especially disturbing trend in sex trafficking. Prior research has noted the occurrence of

forced abortion in victims of sex trafficking outside the United States, but our survivors indicated that they often did not elect to have abortions.

More than half of those who answered the question indicated that their abortions were forced upon them. In addition, many more said they felt forced to choose abortion by the circumstance of being trafficked.

"How can I take care of my baby when he"—her pimp—"forced me out on the street every night to make money?," one victim noted. Another said, "In most of my six abortions, I was under serious pressure from my pimp to abort the babies."

Notably, the phenomenon of forced abortion in sex trafficking transcends the political boundaries of the abortion debate. It violates both the pro-life belief that abortion takes an innocent life and the pro-choice ideal of a woman's freedom to make her own reproductive choices.

Survivors were also the victims of violence and abuse at the hands of their traffickers. 95.1 percent in our study experienced some kind of violence or abuse, as Vednita said, including being shot, strangled, burned, kicked, punched, beaten, stabbed, raped, penetrated with a foreign object.

Survivors also reported threats, intimidation, verbal abuse, and humiliation. Violence was the rule rather than the exception in trafficking. As one survivor said, "My pimp had his girls out on the street every night. It was either you made the quota of money for him or you got beaten."

Many survivors reported being dependent upon drugs and alcohol while they were being trafficked either because the substances were forced on them as a control mechanism by their traffickers or because the substance abuse was a means of coping with their dire circumstances.

84.3 percent reported use or abuse of drugs, alcohol, or both during the time they were trafficked, and the most common substances mentioned were alcohol, marijuana, cocaine, crack cocaine, Ecstasy, and heroin.

Perhaps the most shocking finding of our study was that 87.8 percent of our survivors had sought medical care during the time that they were trafficked. The most frequently reported treatment site was the hospital emergency room, with 63.3 percent saying that they sought health care there.

Survivors also had significant contact with healthcare clinics—that is 57.1 percent—including Planned Parenthood, urgent care clinics, women's clinics, and neighborhood clinics, in that order.

So, clearly, health providers are first responders and they have a unique opportunity to communicate with and to intervene on behalf of victims. And for this reason healthcare providers must be aware of the signs of trafficking in order to identify victims.

An important part of this training will be to help health providers understand the coercive dynamic of trafficking, especially the extreme degree of control exercised by the trafficker and the prevalence of criminal exploitation of women and children. So we need specialized trainings tailored for the healthcare sector. These are a critical part of the solution.

Setting up internal protocols and procedures and regulations may also further assist the healthcare providers in identifying, treating and responding to and reporting as well as referring, where necessary, trafficking victims.

Finally, we absolutely need more research to help us understand the healthcare problems and the needs of trafficking victims as well as to identify best practices and to create national, State, and local responses to health consequences of trafficking.

The medical community can play a vital role in the ongoing fight to eliminate modern-day slavery, and H.R.—whatever the number is going to be—the Trafficking Awareness Training for Health Care Act of 2014, is an important step in helping to equip them for this fight.

And I thank you so much for having us here today to begin this conversation.

[The prepared statement of Ms. Lederer follows:]

Testimony Before the House of Representatives Committee on Energy and Commerce Subcommittee on Health

Hearing

"Examining H.R. ___, the Trafficking Awareness Training for Health Care Act of 2014"

Testimony
Laura J. Lederer
President, Global Centurion
Director, Bastian Center for the Study of Human Trafficking
Washington, D.C.
September 11, 2014

Good afternoon, Mr. Chairman and Members of the Committee. Thank you for the invitation today to testify, and for calling this hearing to address the health effects of human trafficking and the need for training for the healthcare provider sector.

Over the last decade, we have looked at human trafficking as a human rights abuse and a criminal justice problem. In the past five years, it has become clear that human trafficking also has serious public and private health consequences, and that we need public policy and programmatic responses to train health care providers to identify trafficking victims and respond appropriately.

Today I want to share with you the preliminary findings from a series of focus groups we conducted with domestic survivors of sex trafficking around the country. These focus groups provide evidence that women and children who are trafficked into prostitution are physically, mentally, and emotionally devastated by this crime, and this devastation is lasting – with illnesses, injuries, and impairments starting during the trafficking, but lasting often years after.

The full set of findings, in charts and tables, is available in my written testimony. I will outline the basic findings in my testimony here.

Survivors suffer tremendously, virtually without exception. In our study, ***99.1% reported at least one physical health problem during trafficking, and the majority reported dozens of health issues, ranging from neurological, cardiovascular, respiratory, gastrointestinal, gynecological, dental and dermatological problems.***

Survivors were overwhelmingly traumatized not only physically, but also mentally. The brutal treatment they endured created ongoing psychological and mental conditions in many victims and exploited existing mental instability in others. ***98.1% reported at least one psychological issue during their captivity, with an average of more than a dozen psychological health problems indicated, including depression, flashbacks, post traumatic stress disorder, panic attacks, helplessness, hyper-alertness, dissociation, depersonalization, suicide ideation, and attempted suicide.***

Not surprisingly, ***survivors reported significant numbers of reproductive health problems. More that 2/3rds of survivors (67.3%) contracted some form of sexually transmitted disease or infection (STD/STI), including gonorrhea, syphilis, herpes, or Chlamydia.***

Many survivors reported issues around pregnancy. 71.2% of survivors reported at least one pregnancy while being trafficked; 21.2% reported five or more pregnancies. ***54.7% said they had at least one miscarriage and 29.7% had more than one. 55.2% reported at least one abortion, with almost 30% reporting multiple abortions during the time they were trafficked.***

The prevalence of forced abortion is an especially disturbing trend in sex trafficking. Prior research has noted the occurrence of forced abortions in victims of sex trafficking outside the U.S. The survivors in our study indicated that often they did not elect to have abortions. More than half of those who answered the question indicated that their abortions were forced on them. In addition many more said that they felt forced to choose abortion by the circumstance of being trafficked. "How can I take care of a baby when he [her pimp] forces me out on the street every night." One victim noted that "in most of [my six abortions], I was under serious pressure from my pimp to abort the babies." Notably, the phenomenon of forced abortion in sex trafficking transcends the political boundaries of the abortion debate, violating both the pro-life belief that abortion takes innocent life, and the pro-choice ideal of women's freedom to make their own reproductive choices.

Survivors also were the victims of violence and abuse at the hands of their traffickers. ***95.1% in our study experienced some kind of violence or abuse, including being shot, strangled, burned, kicked, punched, beaten, stabbed, raped, or penetrated with a foreign object.*** Survivors also reported threats, intimidation, verbal abuse and humiliation. This violence was the rule rather than the exception. As one survivor said, "My pimp had his girls out on the street every night. It was either you many the [money] for him or you got beat."

Many survivors reported being dependent upon drugs or alcohol while they were being trafficked, either because the substances were forced on them as a control mechanism by their traffickers, or because substance abuse was a means of coping with their dire circumstances. ***84.3% reported use or abuse of drugs, alcohol or both during the time they were trafficked.***

The most common substances were alcohol, marijuana, cocaine, crack cocaine, ecstasy, and heroin.

Perhaps the most shocking finding of our study was ***that 87.8% of survivors had sought medical treatment during the time they were trafficked.*** The most frequently reported treatment site was the hospital/emergency room, with 63.3% saying they sought health care there. Survivors also had significant contact with health care clinics (57.1%) including Planned Parenthoods, urgent care clinics, women's clinics, and neighborhood clinics, in that order.

Clearly, health care providers are "first responders" and have a unique opportunity to communicate with and intervene on behalf of victims. For this reason, health care providers must be aware of the signs of trafficking in order to identify victims. An important part of this training will be to help health care providers understand the coercive dynamic of trafficking, especially the extreme degree of control exercised by the trafficker, and the prevalence of criminal exploitation of women and children. Specialized trainings, tailored for the health care sector, are a critical part of the solution. Setting up internal protocols, procedures, and regulations may also further assist medical care providers in identifying, treating, responding to, and reporting (where necessary) trafficking victims. Finally we need more research to help us understand the health care problems and needs of trafficking victims, as well as to identify best practices, and to create national, state, and local responses to the health consequences of trafficking. The medical community can play a vital role in the ongoing fight to eliminate modern day slavery, and HR ____, the Trafficking Awareness Training for Health Care Act of 2014" is an important step in helping equip them for this fight.

Thank you.

Mr. PITTS. The Chair thanks the gentlelady.

Now recognizes Dr. Stoklosa, 5 minutes for opening statement.

STATEMENT OF HANNI STOKLOSA

Ms. STOKLOSA. Chairman Pitts and Ranking Member Pallone, thank you for inviting me to testify today.

And, Representative Ellmers, thank you so much for putting forth this bill.

And I would also like to express my appreciation to Vednita Carter for her courage in sharing the survivor perspective.

I am an emergency medicine physician at Brigham Women's Hospital in Boston as well as faculty at Harvard Medical School. In Boston, I convened a citywide task force, looking at developing a health protocol for victims of trafficking when they come to our healthcare settings.

In addition, I do international research on human trafficking, including the monitoring and evaluation study of anti-trafficking programs in India as well as looking at the health consequences of human trafficking among construction workers in Kazakhstan.

I co-founded HEAL Trafficking in the fall of 2013. "HEAL" stands for "Health professional, Education, Advocacy, and Linkages." And our vision really is to unite health professionals who are working on the issue of human trafficking.

We are divided into working groups that are working on the issues that are the crux of health and trafficking, including education and training protocols, research, direct service, prevention, and advocacy.

HEAL Trafficking brings together a broad range of health providers, including administrators, researchers, dentists, social workers, nurse practitioners, and physicians. And we are pleased to work very closely, especially our education and training group, with the SOAR initiative within the Department of Health and Human Services.

I am going to share with you a story from the emergency room. This was early on in my training, and it was a busy overnight shift, seeing lots and lots of patients. And I took care of this young woman, who was Cantonese-speaking, who came into the emergency room, and her chief complaint, the main reason that she was there, was she had abdominal pain.

And from a medical perspective, it was a really straightforward case. We diagnosed her with a sexually transmitted infection. We treated her appropriately. And then we discharged her home.

I knew that something wasn't right. I couldn't put my finger on it. And there was this dynamic in the room with an older, also Cantonese-speaking woman, but I didn't have any training on human trafficking. And so I missed this case of human trafficking.

Later on, as I learned what trafficking was and that it was actually happening in the United States, I realized that I missed this opportunity with this young woman, this opportunity to intervene at her time of need in her interface with the healthcare setting.

Unfortunately, this happens all too often. Victims of trafficking are coming to our hospitals and clinics, and they are leaving unrecognized and uncared for.

There are three crucial considerations when we look at developing a healthcare initiative for education of our health providers nationally. These considerations are who, what, and then, "Then what?"

So the "who." And Katherine Chon alluded to this. But we really need to train all healthcare providers across disciplines as well as across specialties. In terms of the disciplines, we need to train social workers, EMTs that are responding in ambulances, physicians, nurse practitioners.

And we need to train across specialties. We need to train obstetrics and gynecology specialists, dermatologists, emergency room providers, surgeons, family medicine providers. We need to train the full spectrum.

And, in addition, we need to train them across the spectrum of their education. So from the physician perspective, from medical school all the way on up to my board-certification process, this needs to be integrated at every stage.

The second is the "what." The content of the training—you know, the Department of Health and Human Services is working on developing the evidence-based content, and I think crucial in that is having trauma-informed, survivor-led expertise.

When I talk to survivors, their everyday "live" experience is often a very deep-seated, complex experience of PTSD due to the repeated physical and emotional and sexual abuse that they experienced during the time that they were exploited, and our health settings and our health providers need to be sensitive to that.

They need to provide a welcoming environment where they aren't even inadvertently revictimizing victims of trafficking. And, if they don't trust the health provider, if they don't trust that setting, there is no way that that health provider is going to get the information they need to be able to identify them as a victim.

The last piece here is that we need to develop a strong referral infrastructure. The current state of resources for survivors is inadequate and disorganized. Just imagine, as we identify further victims of trafficking, what that is going to do to burden our already burdened system.

Survivor care is a long-term process, and survivors need to know that they are better off in our healthcare system than they are in the arms of their exploiter.

So, in summary, who should we train? We should train all healthcare providers. In terms of the "what," it needs to be trauma-informed and survivor-led, and we need to expand resources for referral.

Thank you so much.

[The prepared statement of Ms. Stoklosa follows:]

Testimony Before the House of Representatives Committee on Energy and Commerce
Subcommittee on Health

Hearing

"Examining H.R. ___, the Trafficking Awareness Training for Health Care Act of 2014"

Testimony
Hanni Stoklosa, MD
co-founder, HEAL Trafficking
Emergency Physician, Brigham and Women's Hospital
Clinical Instructor, Harvard Medical School
September 11, 2014

Chairman Pitts, Representative Ellmers, and distinguished members of the Committee, thank you for inviting me to testify today to discuss this important bill which will catalyze the training of our health workforce in caring for this extremely vulnerable population of human trafficking victims. It is an honor and a pleasure to be here.

I am an emergency physician at Brigham and Women's Hospital and faculty at the Harvard Medical School, as well as co-founder of the international organization, HEAL (Health Professional, Education, Advocacy, and Linkages) Trafficking, a network of professionals working on the intersection of health and trafficking. In Boston, I convene a citywide taskforce developing a human trafficking protocol for health facilities. In addition to my clinical and organizational work, I currently lead research on monitoring and evaluation of anti-trafficking programs in India with partners at the Division of Health and Human Rights at the Harvard School of Public Health as well as examine the health consequences of labor trafficking in the construction sector in Kazakhstan in collaboration with the London School of Hygiene and Tropical Medicine. In the context of this testimony I will use the word survivor and victim interchangeably.

HEAL Trafficking was founded in the fall of 2013. Our vision is to unite health professionals and advance their critical role in the national and global fight against human trafficking. Our working groups tackle issues at the crux of health and trafficking, including Education and Training, Protocols, Research, Direct Service, Prevention, Advocacy, Media and Technology, Legal, and International Linkages. HEAL Trafficking brings together physicians, advanced practice clinicians, nurses, dentists, psychologists, counselors, public health workers, health educators, researchers, clinical social workers, administrators, and other health professionals who work with and advocate for the health of survivors of human trafficking. Our education and training group and steering committee have worked closely with the Department of Health and Human Services SOAR Initiative and see its work bridging a crucial awareness and evidence gap in the training of US healthcare providers.

The existing research on human trafficking has shown us that up to eighty-eight percent of human trafficking survivors interface with healthcare, that they present to a range of healthcare settings, and suffer from a myriad of mental and physical health problems. Yet, most health providers are not aware of the presence human trafficking victims within their clinics, emergency departments, and hospitals.

As an emergency medicine physician working on the frontlines, I see the care for victims of trafficking in United States as ad hoc and largely nonexistent. Victims slip through our doors unrecognized.

Imagine having a heart attack and going to the emergency room with chest pain. However, because the clinician caring for you has never heard of your condition, she does not know what questions to ask, what diagnostic tests to order, nor what treatment plan to offer.

Human trafficking is no less life threatening, and yet health providers receive no standardized training in its recognition or care. It is time for this to change.

There are three important points that must be considered in educating our health workforce nationally.

The considerations are 1. Who? 2. What? 3. Then what?

Who? First, **the full gamut of health providers must be trained.** As patients, survivors will interact with a variety of clinicians throughout their care. These include emergency medical service providers, physicians, advanced practice clinicians, nurses, dentists, psychologists, counselors, and clinical social workers, across various medical specialties. We need to ensure that this training is integrated at the initial health professional training as well as certification and re-certification stages. For example, emergency physicians, such as myself, should be trained in human trafficking victim care while in medical school, and this training should be reinforced in subsequent medical licensing exams and board certification processes.

What? Secondly, **the cornerstone of trainings should be an evidence-based, trauma-informed approach**. Survivors of trafficking are living in a reality of complex trauma, yet health providers often have no specific training in a trauma-informed approach. Our health settings see survivors of violence across the lifespan, including child abuse, sexual abuse, intimate partner violence, gang violence, elder abuse, and human trafficking. Many patients are victims of one or more types violence, but without trauma-informed training, well-meaning clinicians and clinics may inadvertently re-traumatize these survivors, missing critical opportunities for intervention. To properly care for this population, the development of trainings and identification- and treatment-protocols must be based on evidence; to that end, more fiscal support for research aimed at expanding our knowledge-base is imperative.

Then what? Third, **we need more resources for survivor referral**. Survivor care does not end the point of identification, but involves a long-term healing process. Training health providers in victim identification and care must been done in concert with enhancing options for referral. The current state of referral options for survivors of trafficking, especially male and labor trafficking

survivors is inadequate. When we train medical providers, more victims will be identified, and there will be an increased demand for survivor services. We need a robust network of resources including longterm mental health provision, housing, and legal services to care for survivors of trafficking after their initial interface with healthcare.

Furthermore, we must enhance our evidence base on human trafficking and health, including our understanding of less understood populations of adult, male, transgender and labor trafficking victims. We must study the effectiveness of healthcare protocols and educational tools for this vulnerable population, ensuring our approach is evidence based and impactful.

Human trafficking is a pervasive and pernicious problem within our borders. Health providers are on the frontlines of victim identification and care, but without empowering clinicians with awareness of the problem or an action plan, victims of trafficking will continue to go through our health facility doors undetected.

In summary, Who should we train? We must train all healthcare providers. What should every training include? All providers must be trained in a trauma-informed approach. Where will providers refer victims? We need to galvanize, increase and improve referral resources for survivors, as current options for referral are quite limited.

Thank you again for the opportunity to testify today and to share the insights from the HEAL network of health providers. We see HR ____, the "Trafficking Awareness Training for Health Care Act of 2014" as a huge step forward in unifying the healthcare response to human trafficking.

Thank you.

The opinions and conclusions expressed in this testimony are the author's alone and should not be interpreted as representing those of Brigham and Women's Hospital or Harvard Medical School.

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Mr. PITTS. The Chair thanks the gentlelady.

And I now recognize Dr. Miller for 5 minutes for an opening statement.

STATEMENT OF KENNETH P. MILLER

Mr. MILLER. Thank you, Chairman Pitts, Ranking Member Pallone, and members of the subcommittee. I appreciate the opportunity to speak with you today on behalf of the American Association of Nurse Practitioners, the largest full-service professional membership organization for NPs of all specialties.

With nearly 52,000 individual members and over 200 organization members, we represent the more than 192,000 nurse practitioners across the Nation.

My name is Ken Miller, and I am currently serving as the President of the American Association of Nurse Practitioners. I have also served in many different academic administrative roles across the country. I have also worked as a family nurse practitioner in New Mexico, Delaware, and the District of Columbia.

NPs have been providing primary, acute, and specialty care for a half a century. We are rapidly becoming the healthcare provider of choice for millions of Americans. In fact, we conducted over 900 million patient visits throughout the United States in 2013.

NPs practice in every community in this country, both urban and rural, and see patients from all economic and social backgrounds. We provide care in all types of settings, which include clinics, hospitals, emergency rooms, urgent care sites, private physician or NP practices, nursing homes, schools, colleges, retail clinics, public health departments, and homeless clinics.

It is also important to remember that, in many of these settings, NPs are the lead provider on site. In fact, there are many NP-owned and -managed clinics across the United States. It is in these various settings, particularly public health departments and primary care clinics, where NPs play a key role in recognizing many of the at-risk, vulnerable populations they treat.

NPs, with their emphasis on primary care, health promotion, and education, coupled with their nursing background, approach the care of their patients holistically.

Their expert assessment and interviewing skills, combined with their education and preparation, uniquely positions them to gather information which not only allows them to treat symptoms, but also research causality, crucial to effective prevention of emotional, physical or sexual abuse.

Knowing the correct assessments to perform and the right questions to ask when treating patients that are victims of other types of violent crime and abuse is a skill set similar to what NPs must call upon when recognizing and treating victims of human trafficking.

We know today that practicing NPs are confronted with patients whom they suspect are victims of human trafficking and that we must lead and work with other provider groups to develop best practices and procedures that will allow all providers to attain the skills needed to ensure that these victims are identified, treated, and assisted.

It is imperative that providers are given clear instruction and guidance on how to identify these victims as well as the steps to be taken to ensure that victims receive the proper protection and care. These best practices need to be carefully developed, given the variety of providers and the different care settings in which these victims may surface.

Victims of human trafficking can be extremely difficult to locate after their initial healthcare visit due to the transient nature of these criminal acts.

It is critical that best practices include a program that provides guidance and gives providers the tools necessary to assist victims as quickly as possible. We must ensure that providers and victims, working together, can develop these evidence-based best practices and work to implement them across the healthcare spectrum.

In closing, it is important to note that strategies may vary from clinic to clinic and from State to State. Developing best practices to identify signs and symptoms and best screening tools is paramount to identifying those who are trafficked.

Reporting procedures are key to removing the victim from their deplorable situation. For any program to be effective, all healthcare professionals that come into contact with suspected victims of abuse must be educated and clinically trained to identify these individuals.

We are pleased to continue to work with Congresswoman Ellmers and other members of the subcommittee to develop legislation that addresses this issue in a provider-neutral manner.

This ensures that all practicing providers and healthcare personnel who may come in contact with victims of human trafficking are able to identify and assist them.

As the voice of nurse practitioners, AANP can reach the rapidly growing NP profession throughout the country with this important information.

We thank you for your time and respectfully request that we continue to work together on this important issue.

[The prepared statement of Mr. Miller follows:]

STATEMENT
Of
Kenneth P. Miller, PhD, RN, CFNP, FAAN, FAANP
To
United States House of Representatives
Committee on Energy & Commerce
Subcommittee on Health
On
"Examining H.R. __, the Trafficking Awareness Training for Health Care Act of 2014"

September 11, 2014

Thank you Chairman Pitts, Ranking Member Pallone, and Members of the Committee. I appreciate the opportunity to speak with you today on behalf of the American Association of Nurse Practitioners (AANP), the largest full service professional membership organization for Nurse Practitioners (NPs) of all specialties. With nearly 52,000 individual members and over 200 organization members, we represent the more than 192,000 nurse practitioners across the nation.

My name is Kenneth Miller and I currently serve as President of AANP. In addition to my position as President of AANP, I am the former Associate Dean for Academic Administration at The Catholic University of America in Washington, DC. I have served as the Director of the School of Nursing for the University of Delaware and was the Vice Dean for Internal Programs and Associate Dean for Research and Clinical Scholarship in the College of Nursing at the University of New Mexico Health Sciences Center. Before my tenure as Vice Dean, I held professorial positions at the Uniformed Services University of the Health Sciences in Bethesda, Maryland. I have also worked as a clinical nurse in medical centers and hospitals in California,

Arizona and Michigan and as a Family Nurse Practitioner in New Mexico, Delaware and the District of Columbia.

As you may know, Nurse Practitioners have been providing primary, acute, and specialty care for half a century. NPs are rapidly becoming the health care provider of choice for millions of Americans. In fact, the trust that patients have in NPs is evidenced by the more than 900 million visits made to them throughout the United States in 2013. NPs practice in every community in this country, both urban and rural, and see patients from all economic and social backgrounds.

Our data shows that the vast majority of NPs in the United States are primary care providers, with 88% of NPs educationally prepared to be primary care providers and over 75% currently practice in primary care settings. NPs bring a comprehensive perspective to health care by blending clinical expertise in diagnosing and treating health conditions with an added emphasis on health promotion and disease prevention. This comprehensive perspective is deeply rooted in NPs' education and background. In fact, all NPs must complete a master's or doctoral program, and have advanced clinical training beyond their initial professional registered nurse preparation. Didactic and clinical courses prepare them with specialized knowledge and clinical competency to practice in a variety of settings.

Daily practice includes assessments, ordering, performing, supervising and interpreting diagnostic and laboratory tests, coordinating care, making diagnoses, initiating and managing treatment, prescribing medications as well as non-pharmacologic treatments, and counselling and educating patients, their families and communities. Additionally, NPs undergo rigorous national certification, periodic peer review, clinical outcome evaluations, and adhere to a code for ethical practice. Self-directed continued learning and professional development is also essential to

maintaining clinical competency. It is important to note that NPs are licensed in all states and the District of Columbia and practice under the rules and regulations of the state in which they are licensed. *The following documents are enclosed for your reference: NP Facts, Scope of Practice for Nurse Practitioners, Standards of Practice for Nurse Practitioners, Quality of Nurse Practitioner Practice.*

Nurse practitioners provide care in all types of settings which include clinics, hospitals, emergency rooms, urgent care sites, private physician or NP practices, nursing homes, schools, colleges, retail clinics, public health departments and homeless clinics. It is also important to remember that in many of these settings nurse practitioners are the lead provider on-site. In fact, there are many Nurse Practitioner owned and managed clinics across the United States. It is in these various settings, particularly public health departments and primary care clinics, where Nurse Practitioners play a key role in recognizing many of the at-risk, vulnerable populations they treat. In many instances, especially in rural and underserved population areas, NPs are the only health care provider.

Nurse Practitioners, with their emphasis on primary care, health promotion and education, coupled with their nursing background, approach the care of their patients holistically. They not only address the physical health care needs of their patients but also factor in the mental and social aspects. Their expert assessment and interviewing skills, combined with their education and preparation uniquely positions them to gather information, which not only allows them to treat symptoms but also research causality crucial to effective prevention of emotional, physical, or sexual abuse. Knowing the correct assessments to perform and the right questions to ask when treating patients that are victims of other types of violent crime and abuse, is a skillset similar to what NPs must call upon when recognizing and treating victims of human trafficking.

We know today that practicing NPs are confronted with patients whom they suspect are victims of human trafficking, and we understand that as the provider of choice to millions of Americans, we must lead and work with other provider groups to develop best practices and procedures that will allow all providers to attain the skills needed to ensure that these victims are identified, treated and assisted. It is imperative that providers are given clear instruction and guidance on how to identify these victims and the steps to be taken to ensure that the victim receives the proper protection and care.

These best practices need to be carefully developed, given the variety of providers and the different care settings in which these victims may surface. Victims of human trafficking can be extremely difficult to locate after their initial health care visit due to the transient nature of these criminal acts. It is imperative that best practices include a program that provides guidance and gives providers the opportunity to assist victims as quickly as possible. We must work to ensure that providers and victims, working together, can develop these evidence based best practices and work to implement them across the health care spectrum. While developing best practices, it is critical that we focus on the services being provided and not the licensure of health care providers. It is important to note, that strategies may vary from clinic to clinic and from state to state. Developing best practices to identify signs and symptoms, and best screening tools is paramount to identifying those who are trafficked, and reporting procedures are key to removing the victim from their deplorable situation. For any program to be effective and to ensure that as many trafficking victims are being identified and assisted as possible, all health care professionals that come into contact with suspected victims of abuse, must be educated and clinically trained to identify these individuals. By casting a broad net to include all health care professionals and personnel, best practices can be shared with the largest number of providers to

impact the greatest number of victims. We are pleased to continue to work with Congresswoman Ellmers to develop legislation that addresses this issue in a provider neutral manner. This ensures that all practicing providers and health care personnel who may come in contact with victims of human trafficking are able to identify and assist them.

In summary, while developing best practices, it is paramount that all health care providers and personnel who are caring for patients are empowered to utilize their education and clinical training to identify and assist trafficking victims. Our organization has been a longtime supporter of the use of common guidelines for the assessment, identification and referral of victims of violence and the inclusion of violence prevention content in educational programs for all health care providers. This type of program is an extension of programs that are already a part of our educational curriculum and in our communities.

The American Association of Nurse Practitioners thanks the Committee and Congresswoman Ellmers for their work on this important topic and we look forward to working together in the development of this project. By working together we can put a stop to the terrible crime of human trafficking. As "*The Voice of the Nurse Practitioner*," AANP can reach the rapidly growing NP profession throughout the country with this important information. We thank you for your time and respectfully request that we continue to work together on this important issue.

Attachments:
1. AANP NP Facts
2. AANP Scope of Practice for Nurse Practitioners
3. AANP Standards of Practice for Nurse Practitioners
4. AANP Quality of Nurse Practitioner Practice

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NP Facts

The Voice of the Nurse Practitioner©

There are more than 192,000 nurse practitioners (NPs) practicing in the U.S.

- An estimated 14,000 new NPs completed their academic programs in 2011-2012
- 95.1% of NPs have graduate degrees
- 96.8% of NPs maintain national certification
- 87.2% of NPs are prepared in primary care; 75.6% of NPs practice in at least one primary care site
- 84.9% of NPs see patients covered by Medicare and 83.9% by Medicaid
- 44.8% of NPs hold hospital privileges; 15.2% have long term care privileges
- 97.2% of NPs prescribe medications, averaging 19 prescriptions per day
- NPs hold prescriptive privilege in all 50 states and D.C., with controlled substances in 49
- The early-2011 mean, full-time NP base salary was $91,310, with average full-time NP total income $98,760
- The majority (69.5%) of NPs see three or more patients per hour
- Malpractice rates remain low; only 2% have been named as primary defendant in a malpractice case
- Nurse practitioners have been in practice an average of 11.7 years

Distribution, Mean Years of Practice, Mean Age by Population Focus

Population	Percent of NPs	Years of Practice	Age
Acute Care	6.3	7.7	46
Adult+	18.9	11.6	50
Family+	48.9	12.8	49
Gerontological+	3.0	11.6	53
Neonatal	2.1	12.2	49
Oncology	1.0	7.7	48
Pediatric+	8.3	12.4	49
Psych/Mental Health	3.2	9.1	54
Women's Health+	8.1	15.5	53

+Primary care focus

Sources:
AANP National NP Database, 2013
Fang, D., Li, Y., Bednash, G.D. (2013) 2012-2013 *Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing.* Washington DC: AACN
2012 AANP Sample Survey
2010 AANP National Practice Site Survey
2011 AANP National NP Compensation Survey

Additional information is available at the AANP website www.aanp.org.

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Scope of Practice for Nurse Practitioners

Professional Role

Nurse practitioners (NPs) are licensed, independent practitioners who practice in ambulatory, acute and long-term care as primary and/or specialty care providers. They provide nursing and medical services to individuals, families and groups accordant with their practice specialties. In addition to diagnosing and managing acute episodic and chronic illnesses, NPs emphasize health promotion and disease prevention. Services include ordering, conducting, supervising, and interpreting diagnostic and laboratory tests, prescribing pharmacological agents and non-pharmacologic therapies, and teaching and counseling patients, among others.

As licensed, independent clinicians, NPs practice autonomously and in collaboration with health care professionals and other individuals. They serve as health care researchers, interdisciplinary consultants and patient advocates.

Education

NPs are advanced practice nurses - health care professionals who have achieved licensure and credentialing well beyond their roles as registered nurses (RNs). All NPs obtain graduate degrees and many go on to earn additional post-master's certificates and doctoral degrees. Didactic and clinical courses provide NPs with specialized knowledge and clinical competency which enable them to practice in primary care, acute care and long-term care settings. Self-directed continued learning and professional development are hallmarks of NP education.

Accountability

The autonomous nature of NP practice requires accountability for health care outcomes and thus national certification, periodic peer review, clinical outcome evaluations, a code for ethical practice, evidence of continued professional development and maintenance of clinical skills. NPs are committed to seeking and sharing information that promotes quality health care and improves clinical outcomes. This is accomplished by leading and participating in both professional and lay health care forums, conducting research and applying findings to clinical practice.

Responsibility

The role of the NP continues to evolve in response to changing societal and health care needs. As leaders in primary and acute health care, NPs combine the roles of providers, mentors, educator, researchers and administrators. They also take responsibility for advancing the work of NPs through involvement in professional organizations and participation in health policy activities at the local, state, national and international levels.

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Standards of Practice for Nurse Practitioners

I. Qualifications

Nurse practitioners are licensed, independent practitioners who provide primary and/or specialty nursing and medical care in ambulatory, acute and long-term care settings. They are registered nurses with specialized, advanced education and clinical competency to provide health and medical care for diverse populations in a variety of primary care, acute and long-term care settings. Master's, post-master's or doctoral preparation is required for entry-level practice (AANP 2006).

II. Process of Care

The nurse practitioner utilizes the scientific process and national standards of care as a framework for managing patient care. This process includes the following components.

A. Assessment of health status

The nurse practitioner assesses health status by:

- Obtaining a relevant health and medical history
- Performing a physical examination based on age and history
- Performing or ordering preventative and diagnostic procedures based on the patient's age and history
- Identifying health and medical risk factors

B. Diagnosis

The nurse practitioner makes a diagnosis by:

- Utilizing critical thinking in the diagnostic process
- Synthesizing and analyzing the collected data
- Formulating a differential diagnosis based on the history, physical examination and diagnostic test results
- Establishing priorities to meet the health and medical needs of the individual, family, or community

C. Development of a treatment plan

The nurse practitioner, together with the patient and family, establishes an evidence-based, mutually acceptable, cost-awareness plan of care that maximizes health potential. Formulation of the treatment plan includes:

- Ordering and interpreting additional diagnostic tests
- Prescribing or ordering appropriate pharmacologic and non-pharmacologic interventions
- Developing a patient education plan
- Recommending consultations or referrals as appropriate

D. Implementation of the plan

Interventions are based upon established priorities. Actions by the nurse practitioners are:

- Individualized
- Consistent with the appropriate plan for care
- Based on scientific principles, theoretical knowledge and clinical expertise
- Consistent with teaching and learning opportunities

E. Follow-up and evaluation of the patient status

The nurse practitioner maintains a process for systematic follow-up by:

- Determining the effectiveness of the treatment plan with documentation of patient care outcomes
- Reassessing and modifying the plan with the patient and family as necessary to achieve health and medical goals

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III. Care Priorities

The nurse practitioner's practice model emphasizes:

A. Patient and family education
The nurse practitioner provides health education and utilizes community resource opportunities for the individual and/or family

B. Facilitation of patient participation in self care.
The nurse practitioner facilitates patient participation in health and medical care by providing information needed to make decisions and choices about:
- Promotion, maintenance and restoration of health
- Consultation with other appropriate health care personnel
- Appropriate utilization of health care resources

C. Promotion of optimal health

D. Provision of continually competent care

E. Facilitation of entry into the health care system

F. The promotion of a safe environment

IV. Interdisciplinary and Collaborative Responsibilities

As a licensed, independent practitioner, the nurse practitioner participates as a team leader and member in the provision of health and medical care, interacting with professional colleagues to provide comprehensive care.

V. Accurate Documentation of Patient Status and Care

The nurse practitioner maintains accurate, legible and confidential records.

VI. Responsibility as Patient Advocate

Ethical and legal standards provide the basis of patient advocacy. As an advocate, the nurse practitioner participates in health policy activities at the local, state, national and international levels.

VII. Quality Assurance and Continued Competence

Nurse practitioners recognize the importance of continued learning through:

A. Participation in quality assurance review, including the systematic, periodic review of records and treatment plans
B. Maintenance of current knowledge by attending continuing education programs
C. Maintenance of certification in compliance with current state law
D. Application of standardized care guidelines in clinical practice

VIII. Adjunct Roles of Nurse Practitioners

Nurse practitioners combine the roles of provider, mentor, educator, researcher, manager and consultant. The nurse practitioner interprets the role of the nurse practitioner to individuals, families and other professionals.

IX. Research as Basis for Practice

Nurse practitioners support research by developing clinical research questions, conducting or participating in studies, and disseminating and incorporating findings into practice.

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Quality of Nurse Practitioner Practice

Nurse practitioners (NPs) are high quality health care providers who practice in primary care, ambulatory, acute care, specialty care, and long-term care. They are registered nurses prepared with specialized advanced education and clinical competency to provide health and medical care for diverse populations in a variety of settings. A graduate degree is required for entry-level practice. The NP role was created in 1965 and over 45 years of research consistently supports the excellent outcomes and high quality of care provided by NPs. The body of evidence supports that the quality of NP care is at least equivalent to that of physician care. This paper provides a summary of a number of important research reports supporting the NP.

Avorn, J., Everitt, D.E., & Baker, M.W. (1991). The neglected medical history and therapeutic choices for abdominal pain. A nationwide study of 799 physicians and nurses. Archives of Internal Medicine, 151(4), 694-698.
A sample of 501 physicians and 298 NPs participated in a study by responding to a hypothetical scenario regarding epigastric pain in a patient with endoscopic findings of diffuse gastritis. They were able to request additional information before recommending treatment. Adequate history-taking resulted in identifying use of aspirin, coffee, cigarettes, and alcohol, paired with psychosocial stress. Compared to NPs, physicians were more likely to prescribe without seeking relevant history. NPs, in contrast, asked more questions and were less likely to recommend prescription medication.

Bakerjian, D. (2008). Care of nursing home residents by advanced practice nurses: A review of the literature. Research in Gerontological Nursing, 1(3), 177-185.
Bakerjian conducted and extensive review of the literature, particularly of NP-led care. She found that long-term care patients managed by NPs were less likely to have geriatric syndromes such as falls, UTIs, pressure ulcers, etc. They also had improved functional status, as well as better managed chronic conditions.

Brown, S.A. & Grimes, D.E. (1995). A meta-analysis of nurse practitioners and nurse midwives in primary care. Nursing Research, 44(6), 332-9.
A meta-analysis of 38 studies comparing a total of 33 patient outcomes of NPs with those of physicians demonstrated that NP outcomes were equivalent to or greater than those of physicians. NP patients had higher levels of compliance with recommendations in studies where provider assignments were randomized and when other means to control patient risks were used. Patient satisfaction and resolution of pathological conditions were greatest for NPs. The NP and physician outcomes were equivalent on all other outcomes.

Congressional Budget Office. (1979). Physician extenders: Their current and future role in medical care delivery. Washington, D.C.: US Government Printing Office.
As early as 1979, the Congressional Budget Office reviewed findings of the numerous studies of NP performance in a variety of settings and concluded that NPs performed as well as physicians with respect to patient outcomes, proper diagnosis, management of specified medical conditions, and frequency of patient satisfaction.

Cooper, M.A., Lindsay, G.M., Kinn, S., Swann, I.J. (2002). Evaluating emergency nurse practitioner services: A randomized controlled trial. Journal of Advanced Nursing, 40(6), 771-730.
A study of 199 patients randomly assigned to emergency NP-led care or physician-led care in the U.K. demonstrated the highest level of satisfaction and clinical documentation for NP care. The outcomes of recovery time, symptom level, missed work, unplanned follow-up, and missed injuries were comparable between the two groups.

Ettner, S.L., Kotlerman, J., Abdelmonem, A., Vazirani, S., Hays, R.D., Shapiro, M., et al. (2006). An alternative approach to reducing the costs of patient care? A controlled trial of the multi-disciplinary doctor-nurse practitioner (MDNP) model. Medical Decision Making, 26, 9-17.
Significant cost savings were demonstrated when 1207 patients in an academic medical center were randomized to either standard treatment or to a physician-NP model.

Horrocks, S., Anderson, E., Salisbury, C. (2002). Systematic review of whether nurse practitioners working in primary care can provide equivalent care to doctors. British Medical Journal, 324, 819-823.
A systematic review of 11 randomized clinical trials and 23 observational studies identified data on outcomes of patient satisfaction, health status, cost, and/or process of care. Patient satisfaction was highest for patients seen by NPs. The health status data and quality of care indicators were too heterogeneous to allow for meta-analysis, although qualitative

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comparisons of the results reported showed comparable outcomes between NPs and physicians. NPs offered more advice/information, had more complete documentation, and had better communication skills than physicians. NPs spent longer time with their patients and performed a greater number of investigations than did physicians. No differences were detected in health status, prescriptions, return visits, or referrals. Equivalency in appropriateness of studies and interpretations of x-rays were identified.

Laurant, M., Reeves, D., Hermens, R., Braspenning, J., Grol, R., & Sibbald, B. (2006). Substitution of doctors by nurses in primary care. Cochrane Database of Systematic Reviews. 2006, Issue 1.
This meta-analysis included 25 articles relating to 16 studies comparing outcomes of primary care nurses (nurses, NPs, clinical nurse specialists, or advance practice nurses) and physicians. The quality of care provided by nurses was as high as that of the physicians. Overall, health outcomes and outcomes such as resource utilization and cost were equivalent for nurses and physicians. The satisfaction level was higher for nurses. Studies included a range of care delivery models, with nurses providing first contact, ongoing care, and urgent care for many of the patient cohorts.

Lenz, E.R., Mundinger, M.O., Kane, R.L., Hopkins, S.C., & Lin, S.X. (2004). Primary care outcomes in patients treated by nurse practitioners or physicians: Two-year follow-up. Medical Care Research and Review 61(3), 332-351.
The outcomes of care in the study described by Mundinger, et al. in 2000 (see below) are further described in this report including two years of follow-up data, confirming continued comparable outcomes for the two groups of patients. No differences were identified in health status, physiologic measures, satisfaction, or use of specialist, emergency room, or inpatient services. Patients assigned to physicians had more primary care visits than those assigned to NPs.

Lin, S.X., Hooker, R.S., Lens, E.R., Hopkins, S.C. (2002). Nurse practitioners and physician assistants in hospital outpatient departments, 1997-1999. Nursing Economics, 20(4), 174-179.
Data from the National Hospital Ambulatory Medical Care Survey (NHAMCS) were used to identify patterns of NP and PA practice styles. NPs were more likely to see patients alone and to be involved in routine examinations, as well as care directed towards wellness, health promotion, disease prevention, and health education than PAs, regardless of the setting type. In contrast , PAs were more likely to provide acute problem management and to involve another person, such as a support staff person or a physician.

Mundinger, M.O., Kane, R.L., Lenz, E.R., Totten, A.M., Tsai, W.Y., Cleary, P.D., et al. (2000). Primary care outcomes in patients treated by nurse practitioners or physicians: A randomized trial. Journal of the American Medical Association, 283(1), 59-68.
The outcomes of care were measured in a study where patients were randomly assigned either to a physician or to an NP for primary care between 1995 and 1997, using patient interviews and health services utilization data. Comparable outcomes were identified, with a total of 1316 patients. After six months of care, health status was equivalent for both patient groups, although patients treated for hypertension by NPs had lower diastolic values. Health service utilization was equivalent at both 6 and 12 months and patient satisfaction was equivalent following the initial visit. The only exception was that at six months, physicians rated higher on one component (provider attributes) of the satisfaction scale.

Newhouse, R. et al (2011). Advanced practice nurse outcomes 1999-2008: A systematic review. Nursing Economic$, 29 (5), 1-22.
The outcomes of NP care were examined through a systematic review of 37 published studies, most of which compared NP outcomes with those of physicians. Outcomes included measures such as patient satisfaction, patient perceived health status, functional status, hospitalizations, ED visits, and bio-markers such as blood glucose, serum lipids, blood pressure. The authors conclude that NP patient outcomes are comparable to those of physicians.

Office of Technology Assessment. (1986). Nurse practitioners, physician assistants, and certified nurse midwives: A policy analysis. Washington D.C.: US Government Printing Office.
The Office of Technology Assessment reviewed studies comparing NP and physician practice, concluding that, "NPs appear to have better communication, counseling, and interviewing skills than physicians have." (p. 19) and that malpractice premiums and rates supported patient satisfaction with NP care, pointing out that successful malpractice rates against NPs remained extremely rare.

Ohman-Strickland, P.A., Orzano, A.J., Hudson, S.V., Solberg, L.I., DiCiccio-Bloom, B., O'Malley, D., et al. (2008). Quality of diabetes care in family medicine practices: Influence of nurse-practitioners and physician's assistants. Annals of Family Medicine, 6(1), 14-22.
The authors conducted a cross-sectional study of 46 practices, measuring adherence to ADA guidelines. They reported that practices with NPs were more likely to perform better on quality measures including appropriate measurement of glycosylated hemoglobin, lips, and microalbumin levels and were more likely to be at target for lipid levels.

Prescott, P.A. & Driscoll, L. (1980). Evaluating nurse practitioner performance. Nurse Practitioner, 1(1), 28-32.
The authors reviewed 26 studies comparing NP and physician care, concluding that NPs scored higher in many areas. These included: amount/depth of discussion regarding child health care, preventative health, and wellness; amount of advice, therapeutic listening, and support offered to patients; completeness of history and follow-up on history findings; completeness of physical examination and interviewing skills; and patient knowledge of the management plan given to them by the provider.

Roblin, D.W., Becker, R., Adams, E.K., Howard, D. H., & Roberts, M.H. (2004). Patient satisfaction with primary care: Does type of practitioner matter? Medical Care, 42(6), 606-623.
A retrospective observational study of 41,209 patient satisfaction surveys randomly sampled between 1997 and 2000 for visits by pediatric and medicine departments identified higher satisfaction with NP and/or PA interactions than those with physicians, for the overall sample and by specific conditions. The only exception was for diabetes visits to the medicine practices, where the satisfaction was higher for physicians.

Sacket, D.L., Spitzer, W. O., Gent, M., & Roberts, M. (1974). The Burlington randomized trial of the nurse practitioner: Health outcomes of patients. Annals of Internal Medicine, 80(2), 137-142.
A sample of 1598 families were randomly allocated, so that two-thirds continued to receive primary care from a family physician and one-third received care from a NP. The outcomes included: mortality, physical function, emotional function, and social function. Results demonstrated comparable outcomes for patients, whether assigned to physician or to NP care. Details from the Burlington trial were also described by Spitzer, et al (see below).

Safriet, B. J. (1992). Health care dollars and regulatory sense: The role of advanced practice nursing. Yale Journal on Regulation, 9(2).
The full Summer 1992 issue of this journal was devoted to the topic of advanced practice nursing, including documenting the cost-effective and high quality care provided, and to call for eliminating regulatory restrictions on their care. Safriet summarized the OTA study concluding that NP care was equivalent to that of physicians and pointed out that 12 of the 14 studies reviewed in this report which showed differences in quality reported higher quality for NP care. Reviewing a range of data on NP productivity, patient satisfaction, and prescribing, and data on nurse midwife practice, Safriet concludes "APNs are proven providers, and removing the many barriers to their practice will only increase their ability to respond to the pressing need for basic health care in our country" (p. 487).

Spitzer, W.O., Sackett, D.L., Sibley, J.C., Roberts, M., Gent, M., Kergin, D.J., Hacket, B.D., & Olynich, A. (1974). The Burlington randomized trial of the nurse practitioner. New England Journal of Medicine, 290 (3), 252-256.
This report provides further details of the Burlington trial, also described by Sackett, et al. (see above). This study involved 2796 patients being randomly assigned to either one of two physicians or to an NP, so that one-third were assigned to NP care, from July 1971 to July 1972. At the end of the period, physical status and satisfaction were comparable between the two groups. The NP group experienced a 5% drop in revenue, associated with absence of billing for NP care. It was hypothesized that the ability to bill for all NP services would have resulted in an actual increased revenue of 9%. NPs functioned alone in 67% of their encounters. Clinical activities were evaluated and it was determined that 69% of NP management was adequate compared to 66% for the physicians. Prescriptions were rated adequate for 71% of NPs compared to 75% for physicians. The conclusion was that "a nurse practitioner can provide first-contact primary clinical care as safely and effectively as a family physician" (p. 255).

Mr. PITTS. The Chair thanks the gentleman.

Thanks to all the witnesses for your very important testimony, very moving testimony.

I will begin questioning and recognize myself, 5 minutes for that purpose.

Ms. Carter, let me start with you. While anyone can become a victim of trafficking, are there certain populations that are especially vulnerable to trafficking?

Ms. CARTER. Yes. There really are. I think the Native American community and African-American women are very highly—they are preyed upon. They are preyed upon.

And those are the communities that—Breaking Free is in Minnesota. And so Minnesota is—less than 10 percent of the population are African-American. Less than 2 percent are Native American.

Yet, still the majority of the 500 women and girls we work with a year are African-American and Native American. So those are the populations that are very highly susceptible to being trafficked.

Mr. PITTS. Thank you.

Ms. Lederer, because human trafficking is considered to be one of the fastest growing criminal industries, the U.S. Government and academic researchers are currently working on an up-to-date estimate of the total number of trafficked persons in the United States annually.

Do you know how they collect this information?

Ms. LEDERER. In the United States?

Mr. PITTS. Yes.

Ms. LEDERER. Chairman Pitts, I don't believe that there is a solid number yet.

I would like to add to what Vednita said. I absolutely agree that those populations are vulnerable, but there are also many other populations that are vulnerable to being trafficked.

We know that runways and the homeless and what we call the throwaway kids, the kids who don't really have homes where they have a loving environment, are very vulnerable to trafficking.

And in all of the survivors that I have interviewed, there was something that happened in the home early on, some abuse, either physical, sexual, that drove these children out on to the streets. And then out on the streets they are much more vulnerable.

We have some estimates of those vulnerable populations. We have heard that it is somewhere between a million and 1.5 that are these runaway, homeless and throwaway youth, and they are all susceptible to trafficking and are preyed upon by traffickers who know exactly what to look for and where to find them.

And so I think that part of what we have done is we have begun to identify large, vulnerable populations, and what we need to do next is take a much more critical laser-like look at what is happening in those populations.

For instance, we know that street gangs are now preying on children in middle schools and that they are literally going to middle schools and high schools and recruiting from there, but we don't know the who, what, when, where, how of that. And we will need specific studies to be able to identify that.

And I am with you. I think we need to be able to figure out on the front end who are these vulnerable populations and prevent the trafficking so that we are not constantly doing the cleanup that we have been doing over the past 10, 15 years.

Mr. PITTS. Thank you.

Dr. Stoklosa, you mentioned your specific patient. You said you missed the stage of trafficking—I think that is what you said—and you must establish trust.

What are the indicators that you look for to identify trafficking victims, in your experience as a physician in Boston?

Ms. STOKLOSA. Thank you for the question.

I would couch this by saying we need more evidence and we need more research to show us what those signs and symptoms are.

But in talking to survivors and from the studies that we have thus far, some of the signs and symptoms—and I kind of go head to toe whenever I train healthcare providers on this—general malnutrition, a discrepancy between their story and what you are seeing.

So they say—just very similar to intimate partner violence, they are saying, "Oh, I fell down the stairs" when there are bruises that are at multiple stages of healing on their body, cuts or lacerations without an explanation, tattoos where they are afraid to talk about them.

Maybe it is a pimp or maybe it is his branding on them. I have spoken with survivors that have been literally hogtied and branded. So that is on the skin side of things.

They may have eye damage from either being beaten or being kept in dark places. And so their vision may be impaired from that. Signs of oral trauma, including sexually transmitted infections that may even present in the mouth. Pulmonary disease. Lung trauma.

And then, on the reproductive side of things, scar tissue that is unexplained, presentations of sexually transmitted infections that have gone farther than one would expect before they sought medical care, and retained foreign bodies either in the vagina or in the rectum, from a female perspective, being forced to have sex during her menses.

I could go on from there, but those are some of the signs and symptoms that would be concerning.

Mr. PITTS. Thank you.

Dr. Miller, health clinics, hospitals, social welfare offices, police, frequently and unknowingly experience face-to-face contact with trafficking victims.

How do you think this bill will help improve identification of trafficking victims from among healthcare providers?

Mr. MILLER. I think one of the most important things that it will do is it will establish a program to educate all healthcare providers.

I think many of us get pieces of that throughout our programs when we are working for our degrees, but I don't think there is any real focus that is totally limited to trafficking.

I think we talk a lot about abuse and we get a lot of information about that, but there is nothing specific to trafficking. And I think having this program will really aid us in being much more astute in identifying patients who are in human trafficking.

Mr. PITTS. Chair thanks the gentlemen, all the witnesses, for your answers.

I have gone over my time. I yield 5 minutes to the ranking member, Mr. Pallone, for questions.

Mr. PALLONE. Thank you, Mr. Chairman.

Earlier this morning we heard from Ms. Chon about the SOAR to Health and Wellness Training initiative at HHS, a pilot program to improve healthcare professionals' response to human trafficking.

I wanted to ask Dr. Stoklosa, since you participated in the technical working group for SOAR, I would like to get your thoughts on this new initiative. The pilot training for SOAR began this week, and it is happening in five States over the next month.

So will you be involved in the training in Boston next week? And what did you see for the type of training that SOAR offers in your community?

Ms. STOKLOSA. Thank you so much for the question.

So both on the HEAL national level as well as individually, I have been really pleased to be involved in the SOAR initiative to health and wellness, and part of it is based on a very well-thought-out process in the development of the curriculum and really addressing this unmet need in terms of educating our health providers.

The HEAL trafficking group, especially the education and training group, has been interfacing both in terms of input on the technical advisory group, both in terms of myself as well as others, and we are really pleased with the ultimate outcome of the pilot training.

But it is that. It is a pilot training. And we are pleased that what this is going to do is add to the evidence base on educating and training our health providers.

Mr. PALLONE. Have you seen much interest in the SOAR program in Boston? And what types of healthcare providers have already signed up for the SOAR pilot training.

Ms. STOKLOSA. So I will be—along with a couple other colleagues, will be doing the training in Boston. And there has been an overwhelming response within the Boston healthcare community, both within my own hospital system as well as across the city of Boston.

And those that have signed up have come from the spectrum of healthcare disciplines as well as specialties, including social workers, dentists, from obstetrics and gynecology to trauma surgeons.

So we are very thrilled to see that response, and I think it is reflective of the hunger for this education and training and the realization that we are interfacing with victims of trafficking, but we don't have the tools, as health providers, to identify them or care for them.

Mr. PALLONE. Well, thanks.

After the pilot sessions this month, participants in SOAR training will complete evaluations of their experience, which will help HHS to assess the effectiveness of the program and determine how to move forward.

What are your hopes for the future of the SOAR training program?

Ms. STOKLOSA. So this is the pilot round, as you said, and my hope is that this will provide an evidence base so that we can have

fidelity for the education and training of health professionals nationally. As Katherine Chon mentioned, this is kind of the 101. This is the general awareness piece.

Certainly every health provider in the United States, once we have shown that this is an effective model, should be trained, and that should be incorporated at all stages, as I mentioned earlier, of our education and training, from the very early stages within professional school all the way along through our accreditation processes as—in whatever board certification or professional accreditation processes are specific to those individual disciplines. And I see HHS really taking a lead in facilitating this effort.

Mr. PALLONE. Well, thanks.

And I want to say I look forward to learning more about the results of this pilot program so we can determine how the Federal Government can best help healthcare professionals along with any other individuals likely to interact with the trafficking victims.

I did want to ask you one more thing, though. This would be either to you or Dr. Lederer.

Current statistics on human trafficking in the U.S. are limited. And as Ms. Chon noted in her testimony, while researchers like Dr. Lederer have begun to look at the health effects of trafficking, more research is clearly needed to better understand the health needs of victims of human trafficking as well as how healthcare professionals can best address the needs.

Could either of you answer: What need do you see for further research regarding the interaction of victims of human trafficking with the healthcare system? Either Ms. Lederer or Dr. Stoklosa or both of you?

Ms. LEDERER. Thank you for the question, which is an excellent question.

I think we are in the foothills of consciousness in terms of figuring out what kind of research needs to be done. I believe that we need to—like Dr. Stoklosa's head to toe, we kind of need to go very beginning and track.

So I have talked to 150 survivors across the United States over the last year, and I have heard recurring themes. And I would start with those recurring themes. One of them is abuse in the home.

Once somebody's been abused, they have been sexually assaulted, they have been raped, they have been molested by a relative, they are pushed out into the streets. And so we need to do a lot more research on the link between early abuse in the home and trafficking.

Then foster care systems. Once they are out of their homes, they are into our foster care system. And we need more research on how foster care system is working. I believe that those systems are failing and are facilitating trafficking at this point in time. So we need more research in that area.

Educational systems. We need more research on the link between bullying and trafficking, on the link between the ways that street gangs and others prey on—what is the role of the educational system right now? How do they facilitate or how are they failing to counter trafficking?

And I can go through each of the various sectors. I think that is important.

I agree with Dr. Stoklosa that all of this needs to begin from the listening to survivors. If we listen to survivors, they can tell us how to proceed. They know the hell of this. They know what works and what doesn't work. They can tell us better than any textbook what we need to do. And so we need to incorporate survivors into all our programs.

And then the last thing I would say is that the huge, huge need, which is the elephant in the room, is the resources and referral. Once we have got these trainings in place—and, Representative Ellmers, thank you so much for taking the lead on this. This has been such a long time coming.

But once we do have these trainings and we begin to identify these victims, we will need thousands of Breaking Frees and we will need to have them up and running so that they can do their work properly.

So there is a lot of research. I would be happy to do a fledgling list for you, just a beginning, and think about this further with my colleagues, but that is a start.

Mr. PALLONE. Thank you.

Ms. STOKLOSA. And, if I may, I would like to add on to that and concur with Laura Lederer's comments.

One of the gaps that I see is the populations that we have data on thus far in terms of intersection with health care. So there is more information, though it is still not as much as I would like, on sort of the pediatric or the child populations specific to sex trafficking.

We don't know a lot about labor trafficking. We don't know as much as I would like about the adult populations and transgender population and boys.

There are a lot of men and boys that are involved in trafficking, and they are largely in a hidden population hidden within that. And they are especially vulnerable, and we don't have much data on them.

The other thing that I would like to add here in terms of the need to add to the evidence base is in terms of going back to trauma-informed care.

Trauma-informed care is something that healthcare providers really have no training on at all. And I mentioned earlier victims of trafficking especially are in this reality that we are not trained to deal with and, as a result, we accidentally, in most cases, re-victimize them when they enter into our health facilities. And, therefore, they are not going to disclose what is really going on.

We need more data around trauma-informed care to show what works and what doesn't work, and we need to train our healthcare workforce in it. And it is not only applicable to victims of trafficking, but we, as healthcare providers, interact with patients that have experienced violence along the entire span of their life, unfortunately, from child abuse to elder abuse, to intimate partner violence. And, yet, we still have no training in trauma-informed care.

So I think, in some ways, this give us an opportunity to expand that very much needed tool kit for healthcare providers. And I would echo Laura's comments in terms of needing more resources

dedicated both to the research as well as to the aftercare for victims of trauma.

Doctors—and I am speaking from that perspective just personally. You don't want to ask the questions if you don't have a plan, if you don't have a solution, to be able to provide.

And so, if you know that the shelters are limited for somebody that is being trafficked, in some ways, it is like an unconscious decision, but you would rather not even ask and explore that. And so we are also missing opportunities because of that.

Mr. PALLONE. Thank you.

Mrs. ELLMERS [presiding]. Thank you. The gentleman yields back.

I am now going to finish up. If any of our other colleagues come in, we will certainly allow them time for questions.

I want to start off—and, at first, I just want to say thank you to our panel. Thank every one of you. Ms. Carter, especially for your bravery for taking your experience and turning it into something positive. It is hard for me to talk about without getting emotional. So I apologize.

We should have done this a long time ago. The fact that we are here today on September 11th—in recognition on a very emotional day for us, as Americans—and talking about this issue, I think is significant.

Ms. CARTER. It is.

Mrs. ELLMERS. And, again, I thank all of you. Because it is all of us working together on this issue where we are going to solve this problem in this country. My goal is to eradicate human trafficking.

And, Dr. Stoklosa, you touched on the labor trafficking that occurs. We are also looking at that, as well, because that is another area that, although we, as Americans, know that it exists, we really don't want to accept that it exists. And we need to be able to identify that.

First, I want to make a comment just about the prevalence here in this country and reference an NIH study in regard to trafficking.

NIH estimates that 50,000 people are trafficked each year in the United States, with as many as 400,000 of our minor children involved in trafficking, resulting in—and this is the question.

The question is: Why is this happening? What is the precipitating factor that creates trafficking? And the answer is the dollars. The dollars. It is a very profitable criminal industry, resulting in billions of dollars being generated from it.

And, Ms. Carter, I want to just go back to your testimony and your experience and now what you are learning when you are working with victims.

One of the things that hit me, working as a nurse for so many years, Dr. Stoklosa, I know exactly what you say when you know something's wrong, but you just can't put your finger on it, and then what would you do if you were to get that knowledge, that information, from that patient.

One of the things that I was struck by was the fact that many of the pimps or the human traffickers that—it is the attraction, the security, and the love that the victim feels that they are receiving from that individual.

Because of their life experience, this may be the most secure thing that they have ever, ever encountered, and that is why sometimes it is so difficult to identify them.

Ms. Carter, can you speak a little bit about that? Is that something that you have also seen?

Ms. CARTER. Yes. Definitely. I want to say it is a brainwashing process because we know that the average age of entry in our country is between 12 and 14 years old. So when you have a 12-year-old that has run away from home, that is out there on the street, it doesn't take a trafficker a lot of effort to convince her that he is going to help her and he understands what she has been through.

So it is kind of like a two-phase process. First, he gets her to believe that he is going to do all these things for her. And, second, he tells her now that she owes him for doing all these things for her.

So at 12 years old, you are full of fear because you have been told that, "If you don't do this, I am going to go and I am going to do this to your sister," "I am going to kill your brother," "I am going to"—you know, just all kinds of threats. So it doesn't take a lot of convincing to get a child involved in this life.

And there are different types of pimps. You have just your hardcore pimp. He knows you are on the run. He knows you are out there, you have no place to go. He immediately just turns you out.

And then you have the other kind that just convinces you that he is everything to you, and she believes it. Why wouldn't she? She can't go get a job. She can't rent an apartment. She can't do anything. And she can't go back home because that is where all the abuse started. So it is a process.

Mrs. ELLMERS. Thank you, Ms. Carter.

Dr. Lederer, one of the things in going over the focus group information that you have provided to us—that was the eye-opening experience that I had.

Again, understanding and knowing the healthcare community and how much any healthcare provider would want to be able to identify these victims and then to find out from your focus groups that 87 percent go to our healthcare providers, to our clinics, to our emergency rooms, and receive care, it was difficult for me to accept that, because I just assumed that these things were happening behind the scenes, they were not out in the open, and that we, as healthcare providers, would not be able to identify those victims.

But when you think about it, it makes perfect sense, because they are the product, and that product has to continue to be sold. So, therefore, they do seek health care. Their traffickers do seek health care.

I realize we are just at the tip of the iceberg here. This is going to be an ongoing discussion into the future so that we can eradicate this terrible, terrible crime.

But one of the things—Dr. Miller, I would like for you to comment on this as well.

As far as expanding, we have all discussed areas where we need to go with this. I do want to go back to our schools, with our school nurses and our social workers.

Dr. Lederer, do you believe that this is an area that we also need to incorporate into these programs?

And then, Dr. Miller, I would like for you to——

Ms. LEDERER. Absolutely I do. And I am not a healthcare provider. So I don't know all of the various subsectors of that sector.

But I think the disappointment over the last 15 years is that all these trainings have been like a one-off. If there has been a training, it has been two things. It is been a hospital calling and saying, "We would like the training to do as part of this seminar that we are putting on. Will you come?" And then the anti-trafficking organization comes, gives a Tip 101, and goes home. So it is not only one off, it is reactive instead of proactive.

And what we need is both proactive and we need a methodical approach. And, again, I like Dr. Stoklosa's approach of, from the beginning, in the academies all the way through all of the sector and the subsectors, we absolutely need training.

And I believe we need training tailored to each of those subsectors. So school nurses will need a specialized training because they are dealing with a specialized community, and they will need to know not only what to look for, but how to respond, you know, properly without driving the kids back out onto the streets, as I think, if you are not equipped, you can do if you are a counselor or a nurse and don't know what to do, what to say, and who to refer to.

So that is a perfect place to begin, and it is at the early stage where, if we can prevent it from happening, we are way ahead of the ballgame. Because once somebody's been trafficked, they are, as we have all been saying, physically, mentally, emotionally, spiritually devastated, and building that person back up again is almost impossible.

We spend a lot of time and money. No one's done the cost-benefit analysis. That is the other big study that needs to be done. How much is this costing to do these rescues, restorations, reintegrations? It is huge. So that is a good place to start.

Mrs. ELLMERS. Dr. Miller.

Mr. MILLER. Yes. I believe that the academic institutions, whether it is grade school, high school, or collegiate level, need to be much more proactive. And the only way they are going to be proactive is if they get the education that they need.

And, again, I can tell you that, in many of the programs around the country, what you hear on abuse is—you may have one or two classes and that is it. And what they really need is to have a workshop, and that workshop needs to be incorporated throughout the entire curriculum for the entire length of time that the person is in the program.

But I also concur that one of the things that needs to be done is it has to be focused on whatever level. If it is a school nurse, if it is a nurse practitioner, if it is a physician, if it is a social worker, whatever their program of study is, it really has to be focused in that area. So that means we are going to have to be developing programs that are really attentive to those types of disciplines.

Mrs. ELLMERS. Thank you.

And my last question—or discussion, really, because I am going to direct this to Dr. Stoklosa, but I would like anyone else who would like to comment as well.

Getting back to the objective that we have—or, obviously, our goal is to incorporate programs, if you figure out ways, protocols, for best practices on all of these issues.

And to the point of prevention, it is so important. Ms. Lederer was talking about the cost or cost-benefit analysis in the long run.

One of the other areas that we are working on here on the House subcommittee is need for mental health reform. And when I think of the number of victims who now fall into and need mental health care, that opens up another door to more cost and continued life situations. They will be affected their entire lives.

What I would like to know, Dr. Stoklosa, from your perspective right now—I was paying special attention to what you were identifying to the chairman about what you see or some of the identifying signs and symptoms that you see today in the emergency room.

One of them, of course, you had mentioned was tattooing and branding, and a light bulb went off in my head and I thought: My goodness, we are talking about modern-day slavery. These women, these children, these men, are being branded.

And we attribute much of that, too, to gang activity, and I can see how healthcare professionals would just make the assumption that this is a gang member or a prostitute on the street and a chosen lifestyle versus someone who would fall into that human-trafficking victim category.

My mind is going crazy with ideas of what we need to do into the future. What do you see now—if a patient comes into the emergency room and you identify them as a potential sex-traffic victim, what do you do from that point on? And what barriers exist that we need to be identifying today so that we know where to go tomorrow?

Ms. STOKLOSA. Thank you for that question.

And you brought up a lot of points along the way that I could spend forever kind of commenting on, but I am going to get to the "what do you do in that moment." And this gets to that kind of "then what?" question.

I am going to speak as a clinician in Massachusetts at the moment. But it depends on age, first of all. So if they are under the age of 18, there are mandated reporting requirements.

And I should say before I even get into the age thing the most important consideration is to meet the victim or the survivor where they are at in that moment.

So, for an under-age-18 individual, I am ultimately going to need to initiate a mandated reporting pathway. If the patient in front of me feels like I am all about rescuing them and doing X, Y, and Z, and I am not there in the moment assessing their needs for food, maybe for water, for just having that human interaction, all is lost, really.

So, under the age of 18, mandated reporting, and that would initiate child protective services. There is also—in Massachusetts, we are lucky enough to have the SEEN Coalition, which is a wrap-around set of services for those that are victims of sexual exploi-

tation under the age of 18, which includes legal services, mental health services.

And we try to limit the number of even health providers that are asking them about their traumatic experience to make sure that it is not re-traumatizing for them in that situation and then referral to services. Obviously, we take care of their medical needs as well.

If they are over the age of 18, it is finding out where they are at and what they want. Maybe it really is just a sandwich. Maybe they are not ready to get out of that situation.

It is very akin, in many ways, to what we have seen with intimate partner violence. They ultimately have agency in that situation. As hard as it is to let them go back out, in some cases, that is the choice that is made.

I see it as a spectrum, that their interaction with caring individuals, whether it be interaction with the healthcare setting or other providers—ultimately, they may get to that point where they are able to say that, "I want to be out of this situation."

We have to recognize that sometimes it is actually less safe for them to disclose that information. They may know that, if some information gets back to their pimp, that they are going to be beaten that evening if they were to disclose.

They may have extreme levels of blackmail that are kind of wielded over their heads either against their family, told that their family's going to be murdered or that pictures are going to be shown to those that love them and care for them.

So we have no idea what is actually going on in their minds, and that is a really important thing for providers to realize. And it is really about meeting them where they are at.

And then, just in terms of the barriers, barriers of judgment on behalf of healthcare providers, as you are saying, they may just be, like, "Oh, this is a prostitute. She is choosing it." A lot of these victims present with substance abuse issues. And what I tell health providers is that those are opportunities for us.

There was a case in New England last year where a health provider asked someone who had come in with a heroine overdose, "You know, I see you have been here a number of times with us. How did you get hooked on heroin?"

And then she reported that it was her pimp. And, from there, they were able to uncover this entire trafficking ring. So it is being aware of the signs and symptoms and really coming at it with that trauma-informed approach.

And then further barriers are on the referral side. So, like, "What then?" You know?

Mrs. ELLMERS. Right.

Ms. STOKLOSA. Have them call the National Human Trafficking Hot Line. They are a great resource for the survivor to talk to. Or, if the survivor is not in that position yet, I can speak in a way that is HIPAA-compliant with the National Human Trafficking Hot Line. So that is also a great resource.

But there have to be resources under that—there have to be roots to that system. If there is no infrastructure for me to refer to, maybe he or she is in some ways better off being in the hands of their exploiter. I mean, it really is a tough state of affairs.

Mrs. ELLMERS. Would anyone else like to comment on this situation of even talking about barriers that exist right now and what we are doing today that in the future we can improve upon?

OK. Dr. Stoklosa, you covered that very well.

I think we are at a point where we can close our meeting. We will have 10 business days to submit questions for the record, and I ask the witnesses to respond to the questions promptly.

I would imagine that many of the members who could not be here for the subcommittee because of ongoing things that are happening today—that you will probably receive some written questions.

And then members should submit their questions by the close of business day on Thursday, September 25th.

Before I adjourn, I just want to thank you again for coming and testifying on this incredibly emotional and vitally important issue. This is something that we can all work on. This is definitely a bipartisan issue that everyone has input on, and we will be able to come together.

And I just feel so strongly that we need to be doing everything we can to make this happen, and I look forward to working with all of you.

Please know that my door is open. The committee is more than happy to take more of your input. And let's work together on the solutions that we need to find.

With that, and without objection, the subcommittee is adjourned.

[Whereupon, at 11:25 a.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

Opening Statement for Chairman Fred Upton

"Examining H.R. 5411, the Trafficking Awareness Training for Health Care Act of 2014"

September 11, 2014

According to the US Department of Justice, human trafficking is the second fastest growing criminal industry — just behind drug trafficking. Sadly, approximately half of all victims are children.

Too often, this is a crime that goes unnoticed and one that is not well understood. It is simply too hard to imagine that it could be happening right here. But it is. Not only does human trafficking occur in the United States, it is a lucrative business with billions of dollars in profits. It happens because these victims are not easily identified and they are afraid. It happens in our own communities, because we are unaware. In order for victims of trafficking to break free, they need help.

Health care professionals who often interact with trafficking victims can be one source of help. Recent studies show that health care professionals are well positioned to be first responders if they have the training and skills to identify victims and meet their needs.

H.R. 5411, the Trafficking Awareness Training for Health Care Act, would provide for the development of evidence-based best practices for health care providers to identify and assist victims of human trafficking. This bill offers us an opportunity to work with the medical community to ensure that human trafficking education and practice becomes a part of health care training.

I would like to thank Rep. Ellmers for introducing this important piece of legislation and I look forward to testimony from today's witnesses about the problem of human trafficking and how the bill will help rescue and restore these victims.

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